BINDING LIST JAN 1 1922

Med.

The Canadian Journal of Medicine and Surgery

A Journal published monthly in the interests of Medicine and Surgery

Vol. XLV. TORONTO, JULY, 1919 No. 7

Editorials

THE ONTARIO MEDICAL ASSOCIATION

The 39th annual meeting of this Association was marked by two special features: the symposium on nephritis (which was the best, Prof. McPhedran said, to which he had ever listened), and the wonderful address on medicine by Sir St. Clair Thompson on "Shakespeare as an Aid in the Art and Practice of Medicine." No doubt this address will appear in full in the records, but those who read it (not having heard Sir St. Clair) have missed a great treat. Those who had the good fortune to be present were greatly impressed with the style of delivery and the interpretation of the great master of English literature by a Victorian type of English gentleman, urbane, cultured and magnetic. The essayist naively enjoyed his own artful presentation of the subject, exhibiting genuine amusement at the presentation of the humorous phases of his subject. Sir St. Clair represents to us Canadians the British ideal of a physician —deep in his sympathies, wide in his mental attainments, high-principled, courteous and cosmopolitan.

171552
18.V.22

R
11
C3E
v.46

The outstanding features of the symposium on nephritis were the illuminating and up-to-date presentation of the laboratory side of the diagnosis of the disease—presented by Professors McLeod and Hunter, and the fine discussion on the therapy of this complaint by Dr. H. O. Mosenthal, of New York, and other American physicians. The members who enjoyed listening will have a fresh conception of the value of the so-called functional tests of the kidney, and will have gained some new practical hints on the medicinal and dietetic management of these difficult cases.

Nothing particularly new was presented by the discussants in the symposium on influenza, except, perhaps, the contribution by Dr. J. P. Norton, who pointed out the frequent importance of sinus and antral complications.

The symposium in war surgery was somewhat disappointing, in that too many papers were crowded into the one evening. The readers of papers felt pressed and hurried through their papers altogether too rapidly; though the material presented was for the most part exceptionally interesting and instructive, it suffered from the rush of presentation. Too much was crammed in too short a space of time. The discussion of Major Waldron and Lt.-Col. Guy Hume, on the Surgery of the Face and Jaws, alone might very profitably have taken the whole evening; or the paper of Col. Menzies on the Surgery of the Thorax; but too crowded in with these—Surgery of the Cranium (which also might have occupied the ses-

sion), the Radiography in the C.A.M.C.; Surgery of the Femur; Surgery of the Knee-joint; Surgery of the Thorax, and a general introduction by Col. Primrose.

We hope to have some additional editorial remarks on the convention in our next issue.

We must congratulate Dr. G. Stewart Cameron, of Peterborough, on his very excellent presidential address, but which lost much from his lack of voice, so that a good deal of what he said was inaudible in the rear of the hall. We are sure, however, it will be widely published and will receive the commendation of the profession generally. And we must congratulate the Association on its choice of the president-elect, Dr. Frederick Marlow.

VACATION

Our short, warm northern summer is with us—and the time for a holiday has arrived. Every active medical man ought to take a rest. Too many do not, with resulting injury to themselves and secondarily to their patients, though they may not think so.

In spite of the good care the average Canadian medical man takes of himself in respect to the use of alcohol and tobacco, it is quite evident that some of them are really overdoing themselves from constant attention to practice. This statement applies more particularly to the present year, on account of the fierceness of the influenzal outbreak, which taxed many practitioners to the utmost.

Canada is full of holiday places: Muskoka, Algonquin Park, the Great Lakes and smaller inland lakes; British Columbia, the Yukon, the Maritime Provinces, the St. Lawrence and the Hudson Bay. There are the quiet spots on Lake Simcoe, Georgian Bay, and along the shores of our big lakes—for the urban doctor—or even the old farm. We urge that every doctor get off for a month if possible.

We must commend the action of the physicians in Trenton (whose *esprit de corps* excels), who have arranged that on Sundays and holidays throughout the summer at least two of them will remain on duty, allowing the others to go off for a change. Every town might follow Trenton's good example for June, July and August; but this arrangement should not bar a month's complete rest and change during the year. Nothing will be lost and much gained—by both doctors and patients. The respite will afford an opportunity for a little reading—medical and general. From the following take along Paget's "Confessio Medici," "The Alabama Student," "Equinimitas" (by Osler), "Romance" (by Conrad); Wells' two best—"Tono Bungay" and "The New Machiavelli"; Oliver Wendell Holmes' Breakfast Table Series and "Elisie Venner"; Stevenson's "Virginibus Puerisque" and "Hyde and Jekyll"; one or two of Weir Mitchell's stories: "The Gold-Headed Cane," "Pickwick Papers," "Great Expectations," "Ivanhoe," "Guy Mannering," John Masefield's and Francis Thompson's poems; a few back numbers of the Atlantic, or perhaps a set of "Dick Carter" and "Service" for the hammock hours and the wet days.

Canadian Journal of Medicine and Surgery

Editors

Surgery:
N. A. POWELL, M.D., C.M., Professor of Medical Jurisprudence, Medical Department, University of Toronto; Senior Assistant Surgeon in charge, Shield's Emergency Hospital.

Clinical Surgery:
ALEX. PRIMROSE, M.B., C.M., Edinburgh University; Associate Professor of Clinical Surgery, Toronto University; Secretary Medical Faculty, Toronto University; Surgeon Toronto General Hospital; and HERBERT A. BRUCE, M.D., F.R.C.S., Eng., Surgeon, Toronto General Hospital.

Orthopædic Surgery:
W. E. GALLIE, M.D., Associate Surgeon, Hospital for Sick Children, Toronto; CLARENCE L. STARR, M.B., Associate Professor of Clinical Surgery, University of Toronto; Surgeon-in-Chief of the Hospital for Sick Children, Toronto; Consulting Surgeon to Toronto General Hospital; H. P. H. GALLOWAY, M.D., Orthopedic Surgeon, Winnipeg General Hospital; Lecturer in Orthopedic Surgery, Manitoba Medical College; Member of The American Orthopedic Association.

Militia and Naval Medical Services and Ambulance:
J. T. FOTHERINGHAM, M.D.; C.M.G.; Colonel, Army Medical Corps, Associate Professor of Medicine and Clinical Medicine, University of Toronto; Associate Collaborator, CHAS. J. COPP, M.D., C.M., Hon. Sec. Provincial Council of Ontario, St. John Ambulance Association.

Medical Jurisprudence and Toxicology:
ARTHUR JUKES JOHNSON, M.B., M.R.C.S. Eng., Coroner for the City of Toronto; Surgeon Toronto Railway Co., Toronto; W. A. YOUNG, M.D., L.R.C.P., Lond., Ex-President of the American Medical Editors' Association; Associate Coroner, City of Toronto.

Hospital Administration:
MRS. AMY A. ARMOUR SMITH, R.N., New Rochelle, N.Y., Ex-Superintendent, New Rochelle Hospital, New Rochelle, N.Y.; A. K. HAYWOOD, M.B., Toronto, M.R.C.S., L.R.C.P., London, Medical Superintendent Montreal General Hospital.

Pediatrics:
ALLEN BAINES, M.D., Toronto; Associate Professor Pediatrics, University of Toronto; Physician, Hospital for Sick Children; HELEN MACMURCHY, M.D., Toronto.

Medicine:
W. J. WILSON, M.D., Toronto, Physician, Toronto Western Hospital; J. H. ELLIOTT, M.D., Associate Medicine and Clinical Medicine, University of Toronto; W. H. PEPLER, M.D., Junior Medical Assistant, St. Michael's Hospital; and A. J. HARRINGTON, M. D., M.R.C.S., Eng., Toronto.

Clinical Medicine:
ALEXANDER MCPHEDRAN, M.D., Professor of Medicine and Clinical Medicine, Toronto University; Physician, Toronto General Hospital; LEWELLYS F. BARKER, M.D., Professor of Medicine, Johns Hopkins University, Baltimore, Md. H. B. ANDERSON, M.D., Toronto; Associate Professor of Clinical Medicine, University of Toronto.

Mental and Nervous Diseases:
N. H. BEEMER, M.D., Mimico Insane Asylum; CAMPBELL MEYERS, M.D., M.R.C.S., L.R.C.P. (London, Eng.), Private Hospital, Deer Park, Toronto.

Gynecology and Obstetrics:
B. P. WATSON, M.D., Edin., F.R.C.S., Edin., Professor of Gynecology and Obstetrics, University of Toronto; Gynecologist and Obstetrician, Toronto General Hospital; GEO T. MCKEOUGH, M.D., M.R.C.S., Eng., Chatham, Ont.; C. F. MOORE, M.D., Toronto; and A. C. HENDRICK, M.A., M.B., F.R.C.S. Edin., Demonstrator in Gynecology, University of Toronto; Assistant Gynecologist, Toronto General Hospital.

Pathology:
J. J. MACKENZIE, B.A., M.B., Professor of Pathology and Bacteriology, University of Toronto; H. K. DETWEILER, M.B., Assistant Pathological Dept., University of Toronto.

Ophthalmology:
J. M. MACCALLUM, M.D., Toronto, Senior Assistant Eye Department, Toronto General Hospital; Oculist and Aurist Victoria Hospital for Sick Children, Toronto. Walter W. Wright, M.B., Assistant in Ophthalmology, Toronto General Hospital and Hospital for Sick Children.

Nose, Throat and Ear:
PERRY G. GOLDSMITH, M.D., 84 Carlton St., Toronto, Laryngologist and Aurist, Provincial Institution for the Deaf and Dumb; Senior Assistant Ear, Nose and Throat Department, Toronto General Hospital.

Dermatology:
D. KING SMITH, M.B., Tor., Toronto; Demonstrator in Pathology, Toronto General Hospital

Managing Editor:
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont.

Address all Communications, Correspondence, Books, Matter regarding Advertising, and make all Cheques, Drafts and Post-Office Orders payable to "The Canadian Journal of Medicine and Surgery," 145 College Street, Toronto, Canada.

Doctors will confer a favor by sending news, reports and papers of interest from any section of the country. Individual experience and theories are also solicited. Contributors must kindly remember that all papers, reports, correspondence, etc., *must be* in our hands by the first of the month previous to publication.

Reprints supplied at Net Cost

Society Proceedings

THE ONTARIO MEDICAL ASSOCIATION MEETING

The 39th annual meeting of this association was held in Toronto on May 27th, 28th and 29th.

Symposium on Influenza.

Dr. Arnold Clarkson traced the history of the disease, as manifested in epidemics which have occurred since the dawn of history. The symptomatology in all epidemics was the same to a great degree. In some outbreaks horses and cattle were affected. The cause of the epidemic in England in 1712 was described by Patriek Walker as a punishment by Providenee because of the recent union with Scotland. Bleeding was found injurious as a mode of treatment.

The epidemie of 1762 in Great Britain affeeted almost everyone. In 1782, beginning in India, the disease spread to China, Siberia, and thence over Europe, laying three-fourths of London low. In 1847 5,000 deaths occurred in the metropolitan district of London. Pulmonary complications were the chief eause of death. During the hot season before, erysipelas was prevalent, a phenomenon noticed in Toronto during the late epidemic. In more reeent years, due to the quicker intercourse between the two continents, as for instance in 1874-75, both America and Europe were affected almost simultaneously. In '89 and '90 the influenza commeneed in Petrograd and Moscow, reached London in June, and New York a month later, and later all the cities of the continent. Every class was affected, barring the deep-sea fishermen. There was a recurrenee in '91, '92, '93 and '94. On the continent the first attack was most fatal. It was rather mild in Great Britain; there the mortality was highest in the second wave. Great prostration among the aged—much

pain in the back and bones, and broncho-pneumonia prevalent. In the recent epidemic the outstanding symptoms were similar to those of previous epidemics, sweating, premature births, great prostration, cyanosis. It has travelled farther and more rapidly over the globe than any other disease. Other epidemics wax and wane, but influenza still remains. Untouched by civilization, uncontrolled by any public health measure, and unchanged by any sanitation or medication we can invent. Dr. W. T. Connell, of Kingston, spoke on the pathology of the disease. We were dealing, he said, with an infection with an especial localization in the respiratory tract and a marked general toxemia. The bacteria predominantly found were the influenza bacillus, the pneumococcus and the streptococcus. There were also found the micrococcus catarrhalis, and the staphylococcus aureus. In favorable cases, after three or four days, the toxemia was overcome. The mortality was low during the early days of the disease. While the respiratory and lung conditions stand out, the accompanying toxemia was of great importance. Dr. Connell had performed no autopsy within three days of the onset. Inflammation of trachea, bronchi with hemorrhage and edema of the lung, parenchymatous degeneration of the liver, kidneys, and heart muscles, with petechiae in the skin and muscular tissues were noted. The majority of the patients died from respiratory complications after the third or fourth day or later, and from secondary infections in which pneumococci and streptococci were predominant.

Pulmonary complications were found in all fatal cases, varying in severity and development. Those dying about the fourth or fifth day showed only marked bronchitis with considerable exudate and edema of the lungs. The lungs were cyanotic and purplish. Microscopic examination invariably showed early features of broncho-pneumonia. The blood was dark and fluid. Later cases showed more lung involvement. The most characteristic morbid feature was the extensive pulmonary edema. Lobular emphysema and lobular collapse and consolidation of one or more lobes were also noted. This consolidation was noted in over one-half the cases. The lobar exudate was hemorrhagic in character. Cases of over a week might show early gray changes. A few showed purulent softening. The pleurae showed

inflammation—fibrin with more or less fluid. In other cases the fluid was purulent in character—these developing usually after the tenth day. Such infections were due to the pneumococcus and streptococcus, though the staphylococcus aureus was found in one or two cases. An occasional phlebitis was encountered. The thrombus showed the pneumococcus. Cases with gastric and intestinal complications showed some catarrhal enteritis and petechial patches in the mucosa of the small intestine. No hemorrhages were observed in the alimentary canal, though the literature speaks of such. There were no definite lesions in the heart. Cloudy swelling was noted. I saw no cases of endocarditis, and but one of pericarditis; and the exudate was purulent. Albumen was present in 50 per cent. of the cases. Definite nephritis was rare; when present it was of the glomerular type —without much fever—attributable to secondary streptococcic infection.

Dr. Connell concluded by saying that the picture was distinctly new to him.

Dr. F. S. Minns presented the following table of statistics:

Toronto Deaths, 1918.

From all causes, per 1,000 per annum	15.6
From influenza and pneumonia	5.54
Average for previous five years from influenza and pneumonia	1.53
Excess of deaths from influenza and pneumonia	4.0
Without epidemic, general rate 15.6-40	11.6
Without epidemic, 1917, general rate	11.8
From all causes	7,635
Influenza	1,408
Pneumonia	1,307
Total	2,715
Normally of influenza and pneumonia	735
Excess	1,980

Deaths from influenza for the months of October, November and December, 1918:

Complicated with broncho-pneumonia	435
Other pneumonias	686
Other complications	107
No complications	138
Total	1,366
	9.8%

ONTARIO.

Deaths from influenza and pneumonia for seven months. October 1st, 1918, to April, 1919, inclusive:

1918—	
October	3,015
November	2,608
December	1,568
Total	7,191
1919—	
January	1,512
February	812
March—Influenza 285, pneumonia 418	703
April—Influenza 137, pneumonia 341	478
Total	3,505
Grand total	10,696
Usual rate from all causes	12.8
Rate for October, November and December	25.7

TORONTO.

Influenza and pneumonia deaths by wards per 100,000:

East to West—

1	2	3	4	5	6	7
296	254	238	205	239	247	213

Death rate at ages, influenza and pneumonia. October and November, 1918:

Age.	Population.	Deaths per 1000.	% of deaths of all ages.	Provincial Nov., 1918.
-10	89,805	1.9	11.8	10.7
10-19	77,976	1.6	8.7	6.1
20-29	122,291	3.5	31.4	52.1
30-39	87,104	3.9	26.8	19.4
40-49	56,125	1.5	6.6	4.6
50-59	35,031	1.7	4.7	2.6
60-69	18,410	1.5	2.6	2.2
70-79	7,515	3.2	1.9	1.9

Rise and fall in deaths from influenza and pneumonia and tuberculosis in all forms:

1918—	Influenza	Pneumonia	Tuberculosis
August	0	23	18
September	2	26	13
October	953	424	45
November	261	171	29
December	152	80	29
January	179	99	28
February	73	56	28
March	55	108	33
April	39	90	40
Total	1,714	1,077	263

Dr. Goldwin Howland dealt with the neurological manifestations of the disease. There were five types of secondary affections of the nervous system: Acute peripheral neuritis, acute poliomyelitis, acute encephalitis lethargica inferior, acute encephalitis superior, and acute psychical. Dr. Howland presented a young girl who in February last had an attack of influenza which lasted one week. A second infection then occurred, accompanied by headache and vomiting. At the end of three or four days she complained of weakness in both arms and legs. Her

arms and legs were still weak and showed considerable atrophy. The weakness was not such as one would see in peripheral neuritis; the whole arm and whole leg were weak. The condition was absolutely symmetrical in arms and legs. There was numbness over the tips of the fingers of both hands and of the feet. The numbness diminishes as you pass up the legs. Both knee-jerks had been lost, but were now recovered. There was a marked facial paralysis on both sides, but the patient was now able to move the muscles of the mouth.

In the acute poliomyelitis type the spinal cord is affected; it was difficult to distinguish from the first class.

Dr. Howland then showed an adult male patient, in whom the secondary infection had attacked the pons-medullary region. There was ptosis of both eyes, and a paralysis of the face similar to the preceding case. The patient was very lethargic, being terribly apathetic and tired. He couldn't think or talk or move about without great effort. There was double vision. In some cases there was difficulty in swallowing from infection of the vagus.

In the fourth type the trouble was up in the cerebrum—in the cortex. Here one may get hemiplegia, a disturbance of the field of vision, catatonia—rigidity, tremor, ataxia; these cerebellar-like conditions may occur where the secondary disease localizes itself. The fifth type is psychical. Mental symptoms develop. Loss of power of perception, and of memory, lethargy, disorientation. The conditions greatly deepen; the patients become comatose and die.

Lumbar puncture shows a clear fluid; the pressure is sometimes increased—rises to about 15 in some cases. Lymphocytes are present and there is an increase in globulin. No definite signs of meningitis.

During the epidemic there has been a great increase in the incidence of rheumatism, accompanied by nervous symptoms. There has been a great increase in the number of cases of facial paralysis, trigeminal neuralgia, neuralgia of the neck and cervical region, sciatica, brachial neuralgia. The epidemic has left people open to infection from other germs. There has been a great increase in neurasthenia and other physical conditions.

Dr. Wm. Goldie dealt with the cardio-vascular manifestations. Patients never died from heart failure *per se* in any disease. This was particularly so in regard to influenza; there is no evidence, clinical or pathological, that the heart ever fails as a separate organ in the course of influenza and pneumonia, unless there be disease from former injury. The failure of circulation is due to changes in the factors that have to do with the circulation, other than the heart. Records of circulation indicate that the heart is inhibited. It is slow and may retain this action almost to the death agony. When all other signs of circulatory failure are present, even with recovery, the pulse-rate rarely exceeds 140; rarely is the heart enlarged; rarely do murmurs develop until long after the onset of circulatory failure. Irregularities are not found unless there has been former disease or defect of the organ. Disorders in the rhythm and force of the pulse make the prognosis increasingly bad. When the patient is failing rapidly from circulatory failure, we don't find failure of the heart—breathlessness, irregularity, etc.; but what is found is cyanosis; the pulse large and lax.

As the cyanosis increases and the patient fails, the pulse is smaller and softer, without corresponding failure of the heart mechanism. The essayist inquired if it might not be due to changes in the hemoglobin and other constituents of the blood. At the onset of cyanosis the peripheral pressure fails. Pathologists have not noted any changes in the heart to account or to explain the circulatory changes.

Dr. J. Gordon Gallie spoke on the Influence of Influenza in Pregnancy. Fifty cases occurred; 17 recovered and 17 died. Of those admitted to the hospital in labor, 9.41% died. Developing during the puerperium, three died, 100%; three died following abortion; two died undelivered, between third and seventh month.

In cases of influenza of the nursing mother, the child was allowed to nurse, providing the mother wore a mask. The milk did not appear to be affected. In his own practice the essayist had eight patients with influenza between the second and the ninth month. None died; one miscarried. As a rule abortion and miscarriage are much more frequent than this. These are

easy in character, the uterine contractions being almost painless. No excess of hemorrhage.

Dr. J. P. Norton, Hamilton, dealt with the ear, nose and throat manifestations of influenza. In the epidemic of the early nineties, lack of mention of the nose and throat complication was a striking feature of the literature. Wechselbaum had mentioned six cases of antral and ethmoidal trouble. Coates considered that sinus influenza was quite accidental.

Until recently nose and throat complications had either been neglected or merely described as accidental. Dr. Connel (a preceding speaker), had not mentioned it at all. Robertson, of Minneapolis, found that sinus influenza is very frequent. The ethmoids, frontals and antra were involved in the order named. Only one of his cases coming to autopsy was free from lesions in the sinuses. These were the ordinary types of tracheitis, bronchitis or broncho-pneumonia, and all on subjects between the ages of 22 and 27. In all instances of sinus involvement these cavities were full of pus. These had been overlooked by the clinicians, by reason of their being engrossed by other symptoms. The involvement of the nasal sinuses, Dr. Norton went on to say, were very common. Many cases of sinus suppuration die if that is the chief trouble. It is impossible to tell whether the sinus involvement is a consequence or a cause of the general condition. Even when it seems to come as a consequence, many cases are due to the organisms pervading the sinuses involved. In different localities disease starts in different ways.

These cases usually start with a slight coryza, a pharyngitis or laryngitis, mitral headaches, due to congestion of the frontal mucous membranes. The frontal sinus condition is quickly relieved by cocaine. There may be herpes labialis and referred pains. Pus is found in the nasal sinuses in many instances. The transilluminator should be used, even when symptoms do not point to infection. Attention to deviated septa is a great factor in preventing patients from contracting influenza, and the good work of removing diseased tonsils should be continued. No doubt the complicating germs, such as the streptococcus hemolyticus may lie in the tonsillar crypt; and if people would have these foci removed fewer of them would have the serious complications connected with the epidemic.

As to masks—in spite of the fact that the germs will pass through several layers—they are a big help. In treating these nasal conditions cocaine with a little epinephrin are very helpful. The nasal douche or spray should not be advised. Ear complications are frequent. One of the principal signs is the raising of the epidermal layers of the drum and the osseous part of the external meatus. The drums in children may rupture completely. In children the drum is much thicker than in adults. The patient may not call attention to his aural symptoms. Marked amelioration of symptoms may be noted when these middle ears are evacuated. Infections of the ears and nasal sinuses no doubt were responsible for many deaths during the epidemic.

The President's Address.

The presidential address was given by Dr. G. Stewart Cameron, of Peterboro. A goodly number of laymen and women were present to hear this and Dr. Thompson's address.

Dr. Cameron prefaced his remarks with a reference to the war and its successful conclusion. The medical organization in connection with the army lived up to in splendid manner a heavy responsibility, he pointed out. As a result of the good work accomplished, thousands of men have been returned to civil life physically fit who would otherwise have been dependents upon the public.

Momentous changes in the world generally are bound to be accompanied by changes in the medical profession, Dr. Cameron continued. The return to civil life of many soldiers, victims of the diversified injuries of war, constitute a need for all practitioners to make themselves acquainted with new developments in connection with all these ailments. "We must develop facilities within ourselves for post-graduate instruction," he declared. "We believe the time has come when in our universities arrangements should be made to provide these."

To Profit by War.

The lessons as to the preventive values of sanitation and serums and vaccines learned in the army should be applied to civil life, he urged. "It is with pleasure that we note the Depart-

ment of Public Health has been created by the Dominion Government." The provision of adequate funds and the removal of the department from politics are needed, and he suggested the establishment of fellowships in this connection. The facts brought to light in the medical examinations carried on under the Military Service Act, when out of 361,395 men examined 181,255 were found lower than Category A, or, in other words, were in some way defective, indicate the need for action for the elimination of preventible defects, he asserted.

The high cost of living threatens to deprive the profession of a class of students from which have come many of its brightest minds, namely, those who are putting themselves through college by their own efforts, the president remarked, and added that much could be done by wealthy citizens to avoid this.

He alluded to the importance to the medical profession of the proposed medical legislation, and he mentioned the need for educating public opinion as to the great work the doctors are doing. Reference was also made to the progress of medical inspection in the schools.

Dr. Cameron spoke of the great burden born by the profession during the influenza epidemic, and to the great many who sacrificed their own lives in their arduous labors. He made special reference to two of these, Dr. Reeve, of Toronto, and Dr. Norman Beal, of London, Ontario.

The speaker praised the work of the nurses overseas, and at home, and commented on the changes under way in the nursing profession, stating that increased remuneration and shorter hours should come.

Sir St. Clair Thompson delivered an address on Shakespeare and the Art of Medicine.

He began by stating that "in the present day, with so much talk of the progress of scientific medicine, of team-work, of a state medical service and so forth, it is important for us to listen to words of wisdom which were written, not for a day, but for all time." If any one of us to-day had to name the one author which every medical man should study deeply, with diligence and delight, surely it would be the greatest of our great Englishmen, William Shakespeare, who died 303 years ago.

The speaker mentioned Shakespeare's many-sided character as discovered in the books of students of his works. "Shakespeare's knowledge of the medicine of his time, his approval of the better part of it, and his reasonableness in praising principally the physiological side of it, is remarkable when we remember that he lived in an age when witchcraft was firmly believed in," he went on.

He proceeded to cite quotations from the great writer's works, evidencing his esteem for the medical profession and alluding to the practice of note-taking, distinguishing between functional and organic disease, the effect of physical condition on mental attitudes, the need for fresh air, the benefits of a change of scene and climate, and of mirth, distractive influences and recreation.

Attitude Towards Alcohol.

"Shakespeare, although making numerous references to alcohol and its use, did not adopt a stand favorable to either total abstinence or over-indulgence," he stated. "Our patients, at least in damp, not to say wet, England, are apt to ask our advice on the subject of alcohol. It is as impossible to saddle Shakespeare with extreme views in regard to alcohol as it is in reference to any other subject on which there is no finality. He is too great an artist and too deep a philosopher to be didactic. He is certainly no advocate of intemperance. Total abstainers may claim him as a supporter on the strength of his commendation, 'Honest water, which ne'er left man i' the mire' (Timon of Athens, i, 2). But he mitigates this commendation with the proviso that water is, 'that which is too weak to be a sinner,' and the rigid prohibitionist may be met with the well-worn quotation: 'Dost thou think because thou art virtuous there shall be no more cakes and ale?' Shakespeare repeatedly paints in vivid colors the loathsomeness and degradation of alcoholic excess, and he is evidently in favor of temperance. How often have we to urge our patients to—

" 'Ask God for temperance. That's the appliance only which your disease requires.' (Henry VIII., I. 1.)

" 'Wine is praised, but always with discretion—'

"'Come, come, good wine is a good familiar creature, if it be well used. Exclaim no more against it.' (Othello II, 8.)

"I am not sure if here, in Canada, you had a No-Treating order; or even know what it means. During the war in the Motherland, in order to reduce the unnecessary consumption of alcoholic beverages, it was ordained by the Defense of the Realm Act, that it was illegal and punishable for any man to stand another a drink. Cassio would have welcomed this order, for when Iago says to him, 'Come, Lieutenant, I have a stoop of wine,' he replied, 'Not to-night, good Iago; I have very poor and unhappy brains for drinking; I could well wish courtesy would invent some other custom of entertainment.' (Othello, II., 3.)"

A Master of Medicine.

Shakespeare mentions the value of diet, sleep, the power of suggestion, encouragement, sympathy and hope, and the importance of prognosis, Sir St. Clair Thompson continued.

Concluding, he said: "We see why Shakespeare is, and always must be, one of the greatest masters of medicine. His astonishing acuteness of observation, his familiarity with the ways and thoughts of frail humanity, his discrimination of diseases, according to age, sex and circumstance; his sensitive regard for 'Life's fitful fever' (Macbeth, III., 2); his sweet reasonableness and deep human sympathy, his profound knowledge of those parts of physiology and pathology which may be studied in the daily life of the street, the market, the tavern, the court, the camp, or the home, are subject to no errors of investigation. They are eternally true.

"The science of medicine progresses, but human nature remains the same, and the foundations of physiology are fixed. Shakespeare plays will be read by physicians when every medical treatise of the present year will be living on the dust heaps of literature, and the works of this master of medicine will continue to be studied by future generations until 'There shall be no more death, neither sorrow nor crying, neither shall there be any more pain.'"

Selected Articles

MINISTRIES OF HEALTH BILL IN GREAT BRITAIN

THE Ministries of Health Bill is the short title of the measure which was introduced by the Minister of Reconstruction recently, and passed its first reading. It is described as

"A Bill to establish a Ministry of Health and a Board of Health to exercise in England and Wales, and in Scotland, respectively, powers with respect to Health and Local Government, and for purposes connected therewith."

Section 1 provides for the appointment of a Minister of Health who shall hold office during His Majesty's pleasure.

Section 2 is as follows:

"*General Powers and Duties of Minister in Relation to Health.* It shall be the duty of the Minister to take all such steps as may be desirable to secure the effective carrying out and co-ordination of measures conducive to the health of the people, including measures for the prevention and cure of diseases, the treatment of physical and mental defects, the collection and preparation of information and statistics relating thereto, and the training of persons engaged in health services."

Section 3 deals with the transfer of Powers and Duties to and from the Minister of Health.

"(1) There shall be transferred to the Minister—

(*a*) All the powers and duties of the Local Government Board;

(*b*) All the powers and duties of the Insurance Commissioners and the Welsh Insurance Commissioners;

(*c*) All the powers of the Board of Education with respect to attending to the health of expectant mothers and nursing mothers, and of children who have not attained the age of five years and are not in attendance at schools recognized by the Board of Education;

(*d*) All the powers of the Privy Council and of the Lord President of the Council under the Midwives Act, 1902;

(*e*) Such powers of supervising the administration of Part I. of the Children Act, 1908 (which relates to infant life protection), as have heretofore been exercised by the Secretary of State."

The power conferred on the Insurance Commissioners to retain and apply for the purposes of research such sums as are mentioned in the National Insurance Act of 1911 will not be transferred to the Minister, but the duties performed by the Medical Research Committee will, under the Act, be carried on by, or under the direction of, the Privy Council appointed by His Majesty for that purpose.

"(2) It shall be lawful for His Majesty from time to time by order-in-Council to transfer to the Minister—

(*a*) All or any of the powers and duties of the Board of Education with respect to the medical inspection and treatment of children and young persons;

(*b*) All or any of the powers and duties of the Minister of Pensions with respect to the health of disabled officers and men after they have left the service;

(*c*) All or any of the powers and duties of the Secretary of State under the Lunacy Acts, 1890 to 1911, and the Mental Deficiency Act, 1913."

Provision is made for the transference from the Ministry of Health to other Government Departments of such matters which could not logically be administered by a Department dealing exclusively with health concerns.

Section 4 makes it lawful to establish consultative councils to give advice and assistance to the Minister.

"Every such council shall include persons of both sexes, and shall consist of persons having practical experience of the matters referred to the council."

Section 5 contains provisions as to Wales. The Minister may establish an office in such town in Wales as he may determine for the exercise and performance of powers or duties transferred to the Minister by the Act from the Welsh Insurance Commissioners.

Section 6 deals with staff and remuneration.

Section 7 provides a seal and defines the style and Acts of the Minister of Health.

Section 8 contains provisions as to orders-in-Council.

Section 9 deals with the application of the Act to Scotland. In the main this does not materially differ from the provisions affecting England and Wales, except that the powers of the Minister of Health in the latter countries will be vested in the Scottish Board of Health, which will be subservient to the Secretary for Scotland. The Board will consist of not more than six members, one of whom must be a medical man holding a public health diploma.

Section 10 defines the attitude of the Act towards Ireland, which is unaffected. The Irish Insurance Commissioners will continue to act under the direction of the Chief Secretary.

Section 11 is headed *"Short Title, Commencement, and Repeal, and Interpretation."* It is provided in this section that the transfer of the powers of the Minister of Pensions shall not be earlier than one year after the termination of the present war. The Local Government Board Act, 1871; The Local Government (Scotland) Act, 1894; and The National Insurance Act, 1911, are repealed to the extent set forth in the third schedule.

An appendix to the memorandum issued on November 25th by the Ministry of Reconstruction defines the composition, powers and duties of the Consultative Councils to be established under Clause 4 of the Bill.

Anent this Bill *The Hospital* says:—

The Need for Organization.

A Bill to establish a Ministry of Health has been introduced

in Parliament. In the nature of things it is wide in scope and void of detail. The thing is it has been introduced. The first step is taken. The new Minister is to take action conducive to the health of the people, including measures for the prevention and cure of disease, the treatment of physical and mental defects.

Prevention, Cure, Treatment. These are portentous words, and surely must portend a State Medical Service, for how else is the Minister to perform duties that include in their scope all of sanitary science and of medical and surgical treatment? "The training of persons engaged in Health Services"—here is weighty work and valuable, if well done. Surely no Minister ever had so great a call, such possibilities of power, as will be given to him who shall first assume the office. It is only temporarily, and whilst means are devised to disentangle the other than medical from the medical duties of the Local Government Board that all its powers and duties are transferred to the new Ministry. It is obviously out of the question for the duties in relation to fire brigades, piers and harbors, steam whistles and emigration to remain with the Minister of Health. These, with other matters, are noted in the first schedule for transfer to, presumably, either a new authority or a reorganized Local Government Board.

The medical profession is in revolution. It will be supremely interesting to see how the wheel will turn. If the medical profession wishes to guide the whirlwind and control the storm, wishes to be master of its own fate, it must organize itself now, take steps, make plans, for soon it will be too late. The medical profession has no collective voice, no organization. The British Medical Association has its uses, but it does not speak for the profession as a whole; its heads are not regarded as representative, even by its own members. The General Medical Council has no authority to speak for the mass of medical men. It is apart from knowledge of the needs of the men in general practice, and has not concerned itself with general medical policy. There are other less important medical bodies, but none to lead, none to advise, none to negotiate with power and authority. If the medical profession is not united and ready to stand shoulder to shoulder it will be kept subordinate in future schemes,

will be put under orders, will be exploited and stampeded, as it has been before. On what happens in the next few years will depend what the medical profession is to be in the future. It may be a subordinate and little-regarded body of men; it may be a powerful organization of scientific men acting in concert and speaking with weight. The public is more concerned in the happenings and their result than the public knows, for it is certain that, if the profession is to be subordinate and little regarded, men of intellect and ability, worthy of regard, will stay out of it. If the profession is to be a powerful and highly-thought-of scientific organization offering good and great rewards for honest and remarkable services, men of ability, men of great intellectual gifts and high ambition, will come in. In the first case the national health will be in the hands of such men as are content to be subservient and little considered. In the second case, in the hands of the best brains in the land.

The time is short, but there is time. The new day is dawning, but its work is not begun. It behooves the profession to arrange itself, to meet and discuss, to organize and make plans. Nothing can be done in these days without collective action and plans prepared in advance. Union is strength. Disorganization soon becomes panic and rout and hopeless defeat. Medical men must show themselves willing to work for and with the community, but they have a right to a weighty voice as to how the work should be done and how it is to be paid. To have that voice they must be ready and able to bargain for due reward for their work in cash, kind, and consideration.

SIX YEARS OF PANEL PRACTICE—ADVANTAGES, DISADVANTAGES AND THE REMEDIES

By J. C. Lyth, M.B.,
B.S. Lond., Member of Council Panel, Medico-Polit. Union.

We have now almost completed the sixth year following the institution of medical benefit under the National Health Insurance Act, and the amending Acts. Of this time more than four years have been spent under the stress of war; and while this has in some ways vitiated the period as a test of panel practice, it has

served to bring out the more rapidly some of the essential characteristics of the system.

The war is practically over; the spirit of reconstruction is in the air. A Bill for the constitution of a Ministry of Health, with wide powers and expressly to supersede the National Health Insurance Commission, is ready for introduction at the coming session of Parliament. It is well, therefore, for practitioners working under the Acts to take stock, to count up their gains and their losses, and to determine whether, and if so under what conditions, it may be worth their while to continue as servants of the State.

I propose then (very briefly in the space at my disposal) to discuss the advantages and the disadvantages which an average general practitioner feels to have been introduced to him by the working of the Acts, and to endeavor to show in what ways the principal grievances felt by the panel practitioners may be removed.

Advantages.

1. A settled income is provided which can be calculated approximately in advance.

2. As a result of this, but for the war, the ease of sale and the market value of practices would have been increased.

3. There is increased ease in introducing a substitute in case of illness or other cause of absence.

4. There is freedom from dispensing (in urban practice) and in sending out of accounts.

5. There are fixed rules for patients (unfortunately honored largely in the breach).

These advantages are not inconsiderable, and some of them have been brought into prominence by war conditions. For example, panel practitioners on war service have been drawing half their panel fees regularly every quarter; further, with the extreme shortage of doctors, it would have been quite impossible to deal with the influenza epidemic had it been necessary to dispense the medicines.

On the debit side, however, the disadvantages loom big, and, as we shall see, some of them are in direct contrast to the promises held out when the system was introduced.

DISADVANTAGES.

1. *Remuneration.*—The capitation fee is less than we had been led to expect; and the payment for work done is actually decreasing, and is relatively much less than for private practice.

In 1912 it was stated (I quote from the official pamphlet) that for every 1,000 persons *on our lists* for the year we should receive at least £325; with the tuberculosis 6d. and the 6d. from the Drug Suspense Fund, £375. Also that we might "confidently rely" on receiving at least 7s. and possibly (with the drug 6d.) 7s. 6d per head per annum of all persons *on our lists.* Yet I have before me the "Final Settlement" issued in my own area for 1916, to a doctor whose list was 968 for that year; that is to say, that all or any of these 968 individuals were entitled to claim treatment from him. It is there stated that the amount due at 7s. per head would be £338 16s., but that in view of an "inflation" of 20.61 per cent., which is stated to have occurred in the lists, the amount paid would be £268 19s. 7d., a difference of some £70. Moreover, that "Final Settlement" was not made until November 25, 1917.

This doctor offered to verify his list at his own expense, but was informed that such a proceeding would be quite useless, and would not affect the payment. I do not propose to enter again into the legal quibble whereby this gross discrepancy has been justified; I am dealing only with facts, and I say such a state of affairs is most unsatisfactory from the practitioner's point of view, and calls urgently for remedy.

In regard to payment for work done, figures collected in my own area show that the sum paid for each attendance recorded is diminishing year by year, probably chiefly because the number of old and otherwise incapacitated insured persons who remain in medical benefit but for whom no fees are paid, is steadily increasing, and must increase for a generation of working life. The attendance value is now considerably less than in 1913. It is hardly necessary to stress the difference between panel fees and the fees for private practice. Not only have the latter advanced very largely in the amount charged, but the receipts are in still higher ratio from the great diminution of bad debts. The result of these figures is shown remarkably in the receipts of

any practitioner having a mixed panel and private practice, where if the two sources of income were as 1 to 1 in 1913 they are now as 1 to 2, or as 1 to 3. How far this condition will change after the war, time only can show, but it seems improbable that money will resume its pre-war purchasing power.

2. *Time Lost in Treating Trivial Ailments and in Dealing with Malingering.*—While this item is necessarily discounted in dealing with payment for work done, it is none the less of an annoying and demoralising character. It is probably inherent in all contract work.

3. *Certification.*—This forms one of the most galling of the petty annoyances of panel practice. Correctly to complete the official forms of certification it is necessary to state that the patient has been examined on the date noted, is suffering from a certain disease, and is incapable of work. This simple matter is rendered extraordinarily complex by the ignorance and downright sheer cussedness of many Approved Society agents, and by the red-tapeism of some of the societies. Certificates are demanded for certain days of the week only; certain diseases are refused recognition; weekly certificates are demanded in chronic cases (*e.g.,* old hemiplegics). With these may be included the remarkable difficulty which many insured persons experience in recovering sick benefit due to them, which re-acts upon the doctor both in his capacity as medical attendant (since it is difficult to make a starving person well) and in the role of guide, philosopher and friend which is so often assigned to him by the patient.

4. *Supply of Medicines.*—Contrary to the statement that "an insured person is entitled to obtain any medicine which the doctor attending him thinks necessary for his treatment," the supply of drugs is severely limited, and only by the strictest economy can a panel practitioner hope to escape the penalty of surcharge.

5. *Lay Control.*—It is probable that a degree of lay control in the matter of complaints is necessary to the working of the Acts, but it is none the less a source of irritation to the average general practitioner that he should be liable to answer for his sins (such as the omission to attend immediately whenever called) before a mixed tribunal such as the Medical Service Sub-Committee.

6. *The Supreme Power of Commissioners.*—The Acts place the supreme decision on all matters in the hands of the National Health Insurance Commission. The Commission may remove a practitioner from the panel; may deduct any sum from the fees due to him; may make any alteration whatever in any of the regulations governing his work at any time without notice; may alter the method of payment and even, indirectly, the amount of payment; and all these without any right of appeal to any court whatever.

It is unfortunate that the tone and methods of the Commissioners in carrying out the duties assigned to them have been such as to bring these facts forcibly before the panel practitioners, and especially those chosen to represent them in any negotiations with the Commissioners. All these powers have been exercised by them at different times; sometimes, as in the case of the regulations for the treatment of discharged soldiers, directly contrary to promises previously made: and have been forced through in spite of the most vigorous protestations of representatives of the practitioners.

Human nature is sadly alike the world over. Place a Prussian in power and you produce a savage bully; substitute a Civil servant, and you create an Insurance Commissioner. Sir E. Cornwall's reply to the request of the British Medical Association and the Medico-Political Union for an increase in the capitation fee stands on record as an instance of how a bureaucrat deals with a learned profession when he has the whip hand.

7. *The Agreement is not a Legal Contract.*—As might be deduced from the above remarks, the agreement under which panel practitioners work is not (according to the advice of eminent counsel) a legal contract, and cannot be enforced at law by either party. But since the Commissioners have the wherewithal to pay the piper, they have the power to call the tune; it is given to the doctors to perform the dance.

Those I think are the principal disadvantages at present attendant upon panel practice. I am not here concerned with defects such as the lack of provision of hospital accommodation, of specialist services, of nursing and the like which are common to all types of medical practice among the working population,

and which it is hoped a Ministry of Health will set to work to rectify.

Remedies.

1. In the matter of remuneration it is suggested that the capitation fee should be raised to at least 10s., irrespective of drugs, and that one-fourth of this sum should be paid for each name on the doctor's list at the end of every quarter. If it is necessary to retain a small percentage (say 5 per cent.) for a final settlement, this should be made within a short fixed period after the termination of the war.

2. Malingering (which is markedly less now than formerly owing to high rates of wages obtaining), would be lessened by the appointment of official referees to whom the practitioners, as well as the societies, might be able to refer difficult patients.

3. Certification should be greatly simplified. Simple fitness or unfitness to follow the occupation should be sufficient, and monthly certificates should be allowed at the doctor's discretion in chronic cases.

4. The money allowed for medicines is insufficient with present prices, and should be increased.

5. The practitioners' agreement should be a legal contract with the right of appeal to common law.

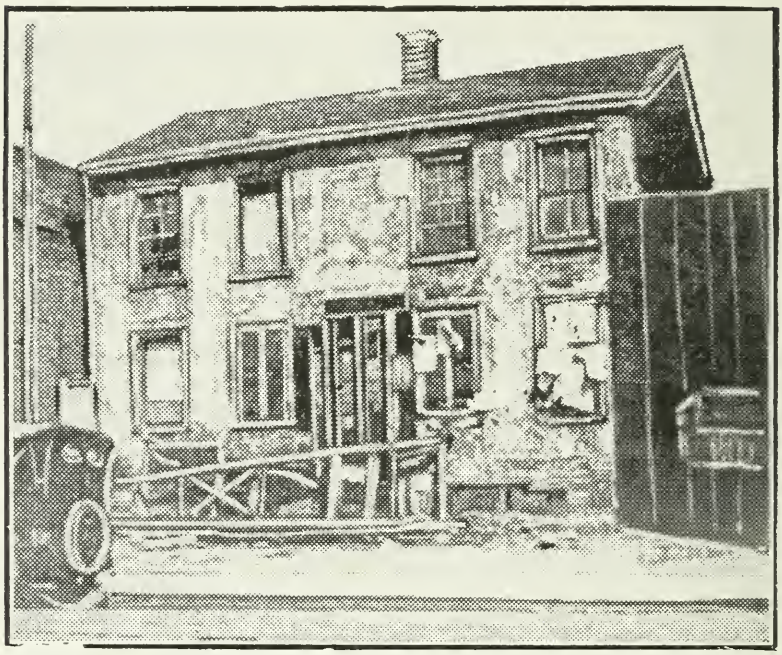
6. Dealings between Government departments and the panel practitioners should be regulated by the appointment of a council or councils, such as are described in the Whitley Report, and foreshadowed in the Ministry of Health Bill. But such councils must be directly representative and have the confidence of the practitioners concerned.

If some such altered conditions as these are introduced I believe that there is a great future before panel practice. Unless essential reforms are made, I consider that it will cease to attract the better class of general practitioner, and will deteriorate to the level of the old club practice. If the medical profession is sufficiently united to seize the present unique opportunity, nothing within reason is beyond reach, and it is my view that the chief hope of such a consummation lies in the present medical trade union movement. But that is another story.—*The Hospital.*

ONE OF TORONTO'S LANDMARKS DEMOLISHED*

ANOTHER of Toronto's old landmarks, and one of those staunchly built houses of the best kind of timber, has recently disappeared. It is at 38 Richmond Street east, and was formerly the residence of two well-known doctors. It is being torn down by Orr Brothers, just east of whose billiard parlors it is located, and was bought by them a few years ago.

For some time it was used as a stable. The following about



the old house is to be found on page 477, vol. 1, of Robertson's Landmarks:

"In 1828, or a little previous to that time, Dr. Peter Diehl, a practitioner of medicine in Montreal, moved from that city to Toronto and began practice here. At first he took up his quarters in the well-known boarding-house of Mrs. Hayes. In November of the year above mentioned he entered into partner-

* The illustration was kindly loaned us by the Toronto Telegram.

ship with Dr. Widmer, the best known physician of York at that time. Some time after this, and before 1836, Dr. Diehl built for a residence and office the two-storey frame house still standing on the north side of Richmond Street east, and now numbered 38. Dr. Diehl was living here at the outbreak of the rebellion. Dr. Diehl died at Toronto March 5, 1868. Many years previous to his demise he sold the Richmond Street house to Dr. John King, for many years a professor in the university. Dr. King was born in Ireland and educated in medicine in Dublin. He came to this country to join his uncle, Wm. Lyons, who was staff surgeon in the British army, and then stationed at Quebec. Another uncle, John Lyons, the brother of William, for many years held the office of registrar at Niagara. Dr. King married the daughter of Speaker Sherwood and settled in Toronto. Dr. Diehl, it may be remarked, had married the sister of Chief Justice Macauley. Dr. King lived in the Richmond Street house, and it is now occupied by his widow. Perhaps of no dwelling in Toronto may it be more truly said that it is a house of grief. Of Mrs. King's family of a husband and eleven children all are dead but one son, who lives in England, and of the dead all but one boy have died in the Richmond Street house. The widow went to England, and when the property was bought in 1903 by Orr Bros. the papers had to be sent to England to be signed."

The house was so well built that men razing it have experienced a great deal of difficulty in pulling it apart.

MY LADY NICOTINE

In summing up an article on "Tobacco and Tobacco Amblyopia," P. Chalmers Jameson, M.D., in the *Long Island Medical Journal*, writes:—

On the one hand we have undoubted testimony from all walks of life of great pleasure and benefit derived from its use; that it combats many of the trials and afflictions of life. It is an antidote to worry, a solace in time of trouble, a lone man's companion; that it harmonizes the feelings, inclines us to forgiveness, promotes good fellowship and peace, soothes a troubled

brain, "breathes contentment round the humble hearth." As to these we have the approval of many well balanced medical men that under certain conditions, principally moderation, it does real physical good, and in combating the worries and irritabilities of life it may add to longevity. On the other hand, the clinical data prove that it is a violent poison in the initiative stages of its use. That in the stage of toleration it is not absolutely innocuous, as in this stage spectroscopic blood changes exist. Blood pressure is raised. Acute symptoms of poisoning sometimes develop, depending upon the amount taken and the susceptibility of the individual, and that after a long period of use certain lesions may appear, such as degenerative changes in the vagus nerve, the cell nerves of the spinal cord and sympathetic ganglia, as also an amblyopia or semi-blindness, in which a lesion of the nerve fibres is demonstrated. On the data presented Dr. Jameson would present the following conclusions:

1. It must be regarded as a slow poison if used in any considerable amount, and that the general opinion that it is always injurious to the young is correct, as it is a poison to the young immature cells.

2. That there are marked differences in susceptibility, and the individual should weigh his own idiosyncracies as a guide to its use.

3. That the existent physical well being in the early life of a smoker is not always an index to harmlessness, as degenerative symptoms may, and do, appear after many years of toleration.

4. That frequent, although intermittent, vascular stimulation must tend, according to the law of cause and effect, to actual degeneration, and excess undoubtedly tends to circulatory and nerve degeneration.

5. That probably what is regarded as moderate smoking, the equivalent of 5 or 6 cigars a day, borders on immoderation from the standpoint of physical well being and longevity.

6. That it undoubtedly is an antidote to worry, promotes good fellowship, renders life more bearable, is one of the least dangerous of the semi-narcotic group, and, above all, does not demoralize.

7. That in many instances the balance of good outweighs the bad influence on body and mind.

8. That to render its use comparatively innocuous and at the same time to derive the joys of peace, calm and solace, it undoubtedly bestows, much greater moderation and limitation of its use should be advocated, and if it were made less of a continuous habit and its use confined to times of worry, mental stress and turbulence, and occasional good fellowship, it would be better for the physical well being of the world who smoke.

GREATER CARE ON THE PART OF THE PHYSICIAN ADVISABLE

GUTMAN, in the *Archives of Diagnosis*, truly says: All credit is due to the surgeon for the manner of handling his cases and the attention he pays to the minutest detail, from the moment of the first incision to the completion of post-operative treatment. Not so with the physician. Were the physician always as careful, painstaking, as persistent, and as thorough in his attention to a case as is the average surgeon, a great deal of surgery and post-operative misery could be avoided. . . . . Physicians should, therefore, give more attention to the patient, exercise greater care and make greater efforts in diagnosis, use more extensively our modern diagnostic facilities, and seek persistently, honestly and energetically the cause of the diseased condition. . . . Every effort should be made to take advantage of every possibility, no matter how painstaking and time-consuming it may be, to come to correct conclusions.

ALUMNAE ELECTS OFFICERS

THE annual meeting of the Medical Alumnae of the University of Toronto was held at the Sherbourne House Club the week of May 5th, when the following officers were elected: Hon. President, Dr. Ida Lynd; President, Dr. Margaret Gordon; Vice-Presidents, Dr. Augusta Stowe-Gullen, Dr. Margaret Johnston, Dr. E. R. Gray, Dr. Mary Roberts, of India; Dr. Bagshaw, of Hamilton; Dr. Bernie, of Peterborough; Secretary, Dr. Catharine F. Woodhouse; Treasurer, Dr. Rowena Hume; Representatives to United Alumnae and National Council, Drs. M. Johnston and M. Gordon.

C.A.M.C. News

Appointments.

Major Julian Southworth Boyd is appointed under the A.D.M.S. Embarkation.

Capt. Harry Clyde Robertson is appointed under the A.D.M.S. Embarkation.

Capt. Frederick Grant Banting, M.C., is posted for duty under the A.D.M.S., M.D. No. 2.

Colonel Samuel Hanford McKee, C.M.G., is posted for duty under the A.D.M.S., M.D. No. 4.

Lieut.-Colonel William Wylie Nasmith is appointed under the A.D.M.S. Embarkation.

Capt. Donald Alexander Warren, M.C., is posted for duty under the A.D.M.S., M.D. No. 2.

Capt. (A.-Major) John Johnston is posted for duty under A.D.M.S., Sanitation, M.D. No. 1.

Capt. Lawrence Roy Shier is posted for duty under the A.D.M.S., M.D. No. 10.

Lieut.-Colonel David King Smith is posted for duty under the A.D.M.S., M.D. No. 2, on ceasing to be employed as Officer Commanding Davisville Military Hospital.

Major Allen Beech is posted for duty under the A.D.M.S., M.D. No. 11.

Capt. John James Danby, from D.D. No. 3, is posted for duty in the Directorate of the D.G.M.S., Ottawa, vice Major Garnet Greer.

Major Louis Wellington MacNutt is posted for duty as Officer Commanding Charlottetown Military Hospital, vice Lieut.-Colonel George Warburton.

Major George Garnet Greer, M.C., is posted for duty under the A.D.M.S., M.D. No. 3.

A.-Major Thomas Albert Watterson, from M.D. No. 6, is appointed Officer Commanding, Fleming Military Convalescent Hospital, Ottawa, vice Major W. H. Ballantyne.

Capt. James Giles Robinson Stone, from D.D. No. 2, is posted for duty on the Directorate of the D.G.M.S., Militia Headquarters, Ottawa.

Capt. James Frederick Stewart Marshall, M.C., is posted for duty under the A.D.M.S., M.D. No. 13, and to be appointed Officer Commanding Ogden Military Convalescent Hospital with effect from 6th May, 1919, vice Capt. A. A. Drinnan.

Capt. George Douglas Jeffs is posted for duty under the A.D.M.S., M.D. No. 2.

Major Colin Andrew McDiarmid is posted for duty under the A.D.M.S., M.D. No. 4.

Major John Alfred Briggs is posted for duty under the A.D.M.S., M.D. No. 4.

Promotions.

Lieut. Philippe Auguste Charette, to be Captain.
Lieut. Harry Herbert Bruser, to be Captain.
Lieut. Elphage Lelande, to be Captain.
Lieut. Didace Romeo Bisson, to be Captain.
Capt. Alexander Gibson, to be acting-Major.

Returned from Overseas.

The undermentioned officers are returned from overseas on general demobilization, for further duty, etc.: Major F. W. Kenny, Major P. Poisson, Lieut.-Colonel Selby, Major W. G. Cosbie, Capt. R. T. Washburn, Capt. J. Gibbs, Major J. T. Wall, Capt. Frank Harvey, Lieut.-Colonel C. A. Young. A.-Lieut.-Colonel D. S. Lomer, D.S.O.; Major W. D. Kennedy, Capt. H. N. Harvie, Capt. A. G. Thompson, Colonel R. P. Wright, Major G. Bouthillier, Capt. J. G. R. Stone, Major R. Mayrand, Capt. E. B. Moles, Major R. B. Robertson, Capt. D. E. S. Wishart, Major C. E. Saint-Pierre, Lieut. G. E. W. Crowe, Major J. F. Burgess, Capt. H. A. Simms, Capt. Millen Alexander Mickle, Lieut.-Colonel Z. Rheaume, Capt. J. L. Hammond, Major Sir Andrew MacPhail, Major W. H. Laughlin, Capt. R. Goulden, Capt. W. E.

Case, Major A. J. Swan, Major F. S. Ruttan, Capt. Lambert Douglas Densmore, Major Leo Errold Parisien, Capt. James Lewin, Major Ralph Marshall Filson, Capt. Emmett Scarlett.

RETIREMENTS.

Major William Hamilton Merritt, on general demobilization.

Lieut.-Colonel George S. McCarthy, on general demobilization.

Capt. Thomas Patton Shaw, on general demobilization.

Capt. Alfred Lawther is struck off strength of the C.E.F. as medically unfit.

Major George Ernest Gillies, on general demobilization.

Lieut.-Colonel Theodore A. Lomer, on general demobilization.

Capt. Evelyn Edwin Robbins, on general demobilization.

Capt. Arthur Chester Armstrong, M.C., medically unfit.

Capt. Joseph Albert Demers, on general demobilization.

Capt. Frederick William Harvey, on assuming duty with the Department of Soldiers' Civil Re-establishment.

Major Henry Pulteney Wright, on general demobilization.

Capt. (A.-Major) Seymour Traynor, on assuming duty with the Board of Pension Commissioners.

Lieut.-Colonel Stephen Rice Jenkins, on general demobilization.

Major Charles Buckingham Shuttleworth, on general demobilization.

Capt. Rupert Stanley Stevens, struck off strength on being medically unfit.

Major Charles Edward Saint-Pierre, on assuming duty with the Department of Soldiers' Re-establishment.

Major Howard Hampden Burnham, on general demobilization.

Major Neil MacLeod, struck off strength as being medically unfit.

Capt. George Sutherland Day, on general demobilization.

Capt. Norman Thomas Beeman, medically unfit.

Major Sir Andrew MacPhail, on general demobilization.

Capt. Charles Francis Dunfield, on general demobilization.

Obituary

DR. A. D. SINCLAIR

Dr. A. D. Sinclair, 290 Danforth Avenue, Toronto, died at his residence on May 25th from double pneumonia. He was born at St. Mary's, Ont., 36 years ago, came to Toronto in 1911 and practised at the above address for five years. Interment took place at St. Mary's on May 27th.

MAJOR (DR.) A. E. McCOLL, BELLEVILLE

Major Allan Evan McColl, one of Belleville's leading physicians, passed away on May 5th, at the age of 57. Dr. McColl was a graduate in medicine of Queen's University, and practiced in Belleville for more than twenty-five years. He had been attached to the C.A.M.C., serving as a Medical Officer, until the Fall of 1917, when he was taken ill, due to overwork.

DR. LUKE TESKEY

Following a few months' illness, Dr. Luke Teskey, for 40 years a practitioner in Toronto, died at his home, 612 Spadina Ave., Toronto, a few weeks ago, from gastritis. He was seventy years of age, was born in Willmott Township, Waterloo County, educated at Trinity College, where he received the degrees of M.D. and C.M., and at an English college, where he received the degree of M.R.C. He retired about five years ago. His widow and three sons, Albert Edward, John Wilfrid and Luke, and two daughters, May and Ada, survive.

The Physician's Library

A Text Book of Pathology, with a final section on Post-Mortem Examinations and the Methods of Preserving and Examining Diseased Tissues. By Francis Delafield, M.D., LL.D., and T. Mitchell Prudden, M.D., LL.D. Eleventh Edition, revised by Francis Carter Wood, M.D. With fifteen full-page plates and eight hundred and nine illustrations in the text, in black and white. New York: William Wood & Company. Price, $7.50. 1919.

Dr. Wood and collaborators are to be congratulated on his successful efforts. The common order of presenting the various divisions of the subject is followed. The sections on autopsy, technique and on methods of preparing specimens have been retained. Many new illustrations have been added, and all pictures are splendid. A good deal of pathological physiology has been introduced. The chapters on tumors, urinary organs, female reproductive organs, and on the bones and joints have come in for special revision. The work will appeal to students and practitioners of all branches of medicine. The chapters on infection and immunity, containing a discussion of micro-organisms to disease, is well worthy of careful perusal and study. To the man who wishes to keep in touch with this very important subject we can cheerfully recommend this work.

Psychological Principles. By James Ward, Professor of Mental Philosophy, Cambridge. Cambridge: At the University Press. New York: G. P. Putnam's Sons. 1919.

Unfortunately few medical men are taught psychology—a serious omission in their training. To make up for this lack they would do well to secure a volume of Ward, the plan of

whose book was laid down over forty years ago. The study of this subject is not easy and its presentation difficult. But the author of this work has presented his matter with rather more lucidity than most writers on the subject, in so far as we have been able to note. The matter is treated subjectively, there being no effort at laboratory exposition, the author holding that all attempts to treat of human experience as merely the culmination of a long but entirely objective development, have been so far marked by serious defects. We commend this book to our readers.

Compend of Surgery for Students and Physicians. By Benjamin Lipshutz, M.D., Instructor in Neuro-Anatomy, Clinical Assistant in Surgery, Jefferson Medical College, Philadelphia; Corinna Borden Keen Research Fellow, Assistant Surgeon, U.S.N.R.F., etc. With 185 illustrations. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street.

A handy little volume for students who wish to quickly review their surgery for examinations. Nurses, too, will find it a useful book for study and reference.

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Articles on Topics of Interest to Students and Practitioners by Leading Members of the Medical Profession Throughout the World. Edited by H. R. M. Landis, M.D., Philadelphia. Volume 1, 29th Series, 1919. Philadelphia and London: The J. B. Lippincott Company.

Out of a number of valuable articles discussed in this volume, one may mention two interesting papers on the recent influenza epidemic, one by Fred Tyee, and another by Robert Wood Keaton.

The Clinical Aspects of Arterial Hypertension, by Augusta Bach, of Paris, with a full discussion of recognized methods of treatment, is a valuable contribution, and should be appreciated by practitioners.

Some 100 pages are devoted to an outline of the progress of Medicine during 1918, a very interesting section of which is

that devoted to a discussion of pneumonia, broncho-pneumonia and influenza.

A work such as *International Clinics* is indispensable to enable the general practitioner to keep abreast with developments in medical diagnosis and treatment.

The Canadian Journal of Mental Hygiene. Volume 1, Number 1. Published quarterly by the Canadian National Committee for Mental Hygiene. Publication office, Toronto. Editorial Office, 121 Bishop Street, Montreal. Subscription price, $2.00 a year, 50c per copy.

We would like to take this opportunity of congratulating the Canadian National Committee for Mental Hygiene on the first issue of this journal. It is certainly one of the cleanest publications that has reached our office for some time past, and its contents are of the highest class. Among the contributors we find the names of such men as Drs. E. E. Southard, C. M. Hincks, C. K. Clarke, H. P. Wright, and J. D. Page; also W. G. Smith, B.A., Peter Sandiford, Ph.D., and R. M. MacIver, D. Phil.

The account of the first year of the National Committee's work is of the greatest interest, as also the Survey of the Province of Manitoba. We feel that, not only members of the Medical Profession, but citizens generally who are interested in this important work, cannot invest two dollars better than by sending in their subscription to the journal for the next year.

Electricity in Medicine. A Practical Exposition of the Methods and Use of Electricity in the Treatment of Disease, comprising Electrophysics, Apparatus, Electrophysiology and Electropathology, Electro-Diagnosis and Electroprognosis, General Electrotherapeutics and Special Electrotherapeutics, by George W. Jacoby, M.D., and J. Ralph Jacoby, A.B., M.D. With 262 illustrations. Philadelphia: P. Blakiston's Son & Co.

To write a book on electricity which the average man can

understand and read with pleasure is no small achievement. This the authors have accomplished in a way that should make this work popular with the general practitioner. The subject is treated comprehensively, and the text is aided by good illustrations. The writers have wisely included a chapter on X-rays, which is well worth reading by every one practising medicine.

Electro-therapy has often suffered through extravagant claims made for its efficacy, and the result has been an attitude of "let it alone" on the part of the medical man. Here, however, the value of electrical treatment is carefully assessed. In fact, no feature of this book is more satisfactory than the frank and conservative way in which the subject is handled. If you doubt this, read the sections on arterial hypertension, hysteria and impotence. One lays the book down reconvinced that electro-therapy has an important place in medicine.

OXFORD COUNTY MEDICAL ASSOCIATION

At a meeting of the Oxford County Medical Association the following were elected officers for the ensuing year: President, Dr. Coulter, Ingersoll; Vice-President, Dr. W. Krupp, Woodstock; Secretary-Treasurer, Dr. Brodie, Woodstock; Treasurer, Dr. Brodie, Woodstock; Executive: Drs. Andrew McKay, M. Brownlee and G. M. Brodie, Woodstock, and Drs. Canfield and Cornish, Ingersoll.

AN IDEAL RESORT FOR CONVALESCENT PATIENTS*

Physicians have frequent opportunities of referring those convalescing from illness to a resort where they can quickly recover their old-time vigor and enjoy an almost ideal climate, 2,500 feet above sea level. Such a resort is Virginia Hot Springs, just one night out of New York. The management have spent a huge sum of money on this choice spot in "Old Virginny," and are anxious that the Canadian medical profession should continue to refer cases there, as they have done in years gone by. The Homestead Hotel is one of the handsomest houses in America. It is built of solid brick, containing 500 guest rooms, with many parlor suites and 300 private baths. It is spacious, dignified, quiet and restful, with magnificent mountain views on every side. It is no exaggeration to say that Hot Springs means the Homestead Hotel. The Company owns 5,000 acres surrounding the hotel, so that physicians can understand that their patients have every opportunity of enjoying outdoor life and regaining thereby their normal strength.

The dominant factor making Hot Springs world-famous is the cure in which the climate as well as the water assist. The waters are conducted by gravity to the bathhouse and distributed fresh from the ground to the bathing apartments on different floors without loss of heat or its increase by artificial means, and fully charged with all their gases and other health-giving qualities. At none of the celebrated places in Europe, and at no other springs in America, is the temperature prescribed for hot baths that at which the water actually emerges from the earth in the natural springs.

The springs are beneficial, not only for bathing, but for drinking. Besides the hot springs, the effects of which as drinking waters are pronounced, there are magnesia, sulphur, and soda springs within the grounds, and alum water from a spring not far distant. The water from the soda spring comes strong and clear from the ground at a uniform temperature of 74 degrees. Physicians should address for full information Christian S. Andersen, Esq.

* Publisher's Department.

The Canadian Journal of Medicine and Surgery

A Journal published monthly in the interests of Medicine and Surgery

Vol. XLVI. TORONTO, AUGUST, 1919 No. 2

Editorials

CANADIAN MEDICAL ASSOCIATION

FIFTY years ago this Association, under the presidency of Sir Charles Tupper, was founded in the very room in Laval University in which the general sessions of the recent meeting were held. Not one of the charter members is now alive. A Toronto delegate, Dr. Adam Wright, who was a medical student in Toronto in those days, remembers the inaugural meeting, and recalls that Drs. Hodder and Thorburn, of Toronto, went down to it. This year's meeting was presided over by Dr. S. Grondin. In his able address, he recommended more co-operation between the English and French doctors. To this end Laval University, he said, was prepared to open its courses free of charge for a period of one year to all young doctors who graduate from such other Canadian universities as will reciprocate. This announcement was received warmly.

Dr. Frederick Marlow, following Dr. Grondin, stated that if the time he had been compelled to spend in studying dead languages and a language which ought to be dead—(laughter and applause) —in learning French, it would have been a great advantage. These addresses were delivered at the annual banquet, which was an enthusiastic affair. It is said there was no trouble in spotting the Ontario delegates, because of the avidity they showed for the wine on the table. Dr. A. Valee, the local secretary of the Committee on Arrangements, Professor of Pathology at Laval, delivered an impassioned address in French, in which he prophesied what would be accomplished by the science of medicine during the period of reconstruction as an influence in cementing the Canadian peoples in a lasting union. As an example of the possibilities open to medical men in respect to national affairs, he referred to the high order of statesmanship shown by Doctor Clemenceau. Doctor Blackader, of Montreal, said that in Quebec Province the medical men of British and of French origin lived as brothers; he was proud to regard his French-Canadian fellow practitioners in such an intimate relationship.

In addition to the banquet there were several pleasant social functions, notably the garden party and reception at Government House, where Sir Charles and Lady Fitzpatrick welcomed the guests in a cordial manner. The afternoon was ideal, and

the guests enjoyed not only the unassuming hospitality, but also the historic scenic beauty of Spencerwood. A few yards away is the gulch up which Wolfe made his famous ascent, and adjacent lie the Plains of Abraham, where in a half-hour battle he won Canada for the British.

The delegates were also given a boat trip to the gigantic cantilever bridge which spans the majestic river. The wives of the visiting doctors were entertained at a garden party given by the wife of Colonel Rose; and the delegates were taken in autos to visit the new 100-bed tuberculosis hospital at St. Foyé, a solid brick modern building, costing $300,000, erected on a beautiful 140-acre estate, the only institution of the sort in Quebec. Dr. A. Rousseau, of Quebec city, has labored untiringly for seven years in planning and raising funds for its establishment; and the people of Quebec are very much indebted to him for his efforts in behalf of the tuberculous sick in that province. Doctor Rousseau presided over the medical section of the congress, and contributed a valuable paper on "*De quelques notions clinique et pathogenique elementaire sur l'oedeme actif.*" Quite a proportion of the addresses were in French.

The new draft copy of the by-laws was referred back to the executive, and will be further revised by a sub-committee.

Considerable interest was manifested in a resolution of Doctor Bruce, criticizing the Government

in regard to certain matters affecting the C.A.M.C. Getting wind of the proposed resolution, one of the members of the executive introduced a resolution to the effect that resolutions of a political character should not be considered. This motion was lost by the casting vote of the chairman. Doctor Bruce's motion was then placed by him in the hands of a proxy, as he was obliged to leave for Toronto a few minutes before this. The motion included a paragraph commending the work done by Canadian doctors, nurses and ambulance men at the Front; another censuring the Government for its failures and mismanagement, and a recommendation that provision should be made for training army medical officers, and that they should be adequately paid. At the suggestion of the delegate in charge of the resolution (a Government employee), the paragraph censuring the Government was deleted, but the other two passed unanimously. *Apropos* of this incident, Doctor Bruce's new book, "Politics and the C.A.M.C.," came out on the second day of the convention, and the book was perused with great interest, more particularly because of the summary treatment accorded Doctor Bruce by the authorities, and because of the suppression of his reply to the findings of the Baptie Commission.

There were some two hundred members present, and many excellent papers were presented, notably the scholarly Address in Medicine by Prof. W. S. Thayer, of Baltimore, on "Lænnec," and the very

practical Address in Surgery by Prof. Jasper Halpenny, of Winnipeg, who discussed hospitals and their responsibility to their patients through the work and training of their surgeons. In this number we shall give a report of these and of some other of the addresses we were able to secure.

A word of commendation is due Dr. J. W. S. McCullough, who, with a number of his associates in Ontario, did so much to make the Public Health Section so interesting. The doctor's admirable paper on "Sanitation and the War" was much appreciated. Other excellent phases of the meeting we hope to refer to in ensuing numbers of this journal.

PATENT MEDICINE CURES

THE American Medical Association, through its Propaganda Department, has done good work for the innocent public by its investigation of fake cures. Its results appear in small pamphlets which can be secured for a few cents each. Among the brochures already issued are ones on "Epilepsy Cures," "Deafness Cures," "Consumption Cures," "Nostrums for Kidney Diseases and Diabetes," "Obesity Cures," "Female Weakness Cures," "Cosmetic Nostrums and Allied Preparations," "Cancer Cure Fakes," "Some Mechanical Cure-Alls," "The Great American Fraud" (being Samuel Hopkins Adams' articles on the nostrum evils contributed to *Col-*

lier's), "Some Quasi-Medical Institutions," "Medical Institutes," "Medical Mail Order Frauds," "Men's Specialists" (some quacks and their methods, reprinted from the *Chicago Tribune*), "At the Bar of Public Opinion" (what some newspapers and magazine editors think of the patent medicine business and quackery), "Miscellaneous Nostrums," "Some Miscellaneous Specialists," "Testimonials" (medical and quasi-medical from the *New York Tribune*), and "Mineral Waters." A couple of dollars will pay for the bunch, and they make amusing and painful reading. So many patients and "friends" inquire what their medical adviser thinks of such and such a cure-all, about which, perhaps, he has never heard, that it will pay him to secure this series in order to make some specific replies to his questioners. We strongly advise all our readers to secure the series.

In addition to the above-mentioned series, the A.M.A. has published a book on nostrums and quackery, being a reprint of articles which have from time to time appeared in the *A.M.A. Journal*. This book can be secured at a nominal price and will make a good investment for every practitioner. Address: The Propaganda Department of the Journal of the American Association, 535 North Dearborn St., Chicago, Ill., U.S.A. If any of our subscribers wish to know anything in respect to the composition of any quack remedies about which they are asked, Dr. Albert Cramp, head of the Propaganda Department, will be glad to enlighten them on the subject.

DOPE DENIED

Dr. Henri Beland on May 15th led an attack against the clause in the Patent Medicines Act which provides that all proprietary or patent medicines containing opium or any derivative of coal tar, and intended for administration to children over one year of age, will be labelled "dangerous for infants under one year old." Dr. Beland attacked the so-called soothing syrups, calling attention to the baneful results from their use. Dr. M. Steele supported Dr. Beland's contention, remarking that simply labelling a bottle "dangerous" was futile.

Dr. R. J. Manion, M.C., the well-known war author, of Fort William, recommended a clean sweep of the whole business by giving cocaine, opium and similar drugs a knockout blow.

Dr. Beland introduced a resolution calling for the prohibition of the manufacture, importation or sale of all patent medicines containing opium and its derivatives intended for internal use.

At this writing the clause is allowed to stand, as the Minister in charge of the bill is not quite satisfied with the wording of it. We trust the resolution will carry.

Canadian Journal of Medicine and Surgery

Editors

Surgery:
N. A. Powell, M.D., C.M., Professor of Medical Jurisprudence, Medical Department, University of Toronto; Senior Assistant Surgeon in charge, Shield's Emergency Hospital.

Clinical Surgery:
Alex. Primrose, M.B., C.M., Edinburgh University; Associate Professor of Clinical Surgery, Toronto University; Secretary Medical Faculty, Toronto University; Surgeon Toronto General Hospital; and Herbert A. Bruce, M.D., F.R.C.S., Eng., Surgeon, Toronto General Hospital.

Orthopedic Surgery:
W. E. Gallie, M.D, Associate Surgeon, Hospital for Sick Children, Toronto; Clarence L. Starr, M.B., Associate Professor of Clinical Surgery, University of Toronto; Surgeon-in-Chief of the Hospital for Sick Children, Toronto; Consulting Surgeon to Toronto General Hospital; H. P. H. Galloway, M.D., Orthopedic Surgeon, Winnipeg General Hospital; Lecturer in Orthopedic Surgery, Manitoba Medical College; Member of The American Orthopedic Association.

Militia and Naval Medical Services and Ambulance:
J. T. Fotheringham, M.D.; C.M.G.; Colonel, Army Medical Corps, Associate Professor of Medicine and Clinical Medicine, University of Toronto; Associate Collaborator, Chas. J. Copp, M.D., C.M., Hon. Sec. Provincial Council of Ontario, St. John Ambulance Association.

Medical Jurisprudence and Toxicology:
Arthur Jukes Johnson, M.B., M.R.C.S. Eng., Coroner for the City of Toronto; Surgeon Toronto Railway Co., Toronto; W. A. Young, M.D., L.R.C.P., Lond., Ex-President of the American Medical Editors' Association; Associate Coroner, City of Toronto.

Hospital Administration:
Mrs. Amy A. Armour Smith, R.N., New Rochelle, N.Y., Ex-Superintendent, New Rochelle Hospital, New Rochelle, N.Y.; A. K. Haywood, M.B., Toronto, M.R.C.S., L.R.C.P., London, Medical Superintendent Montreal General Hospital.

Pediatrics:
Allen Baines, M.D., Toronto; Associate Professor Pediatrics, University of Toronto; Physician, Hospital for Sick Children; Helen MacMurchy, M.D., Toronto.

Medicine:
W. J. Wilson, M.D., Toronto, Physician, Toronto Western Hospital; J. H. Elliott M.D., Associate Medicine and Clinical Medicine, University of Toronto; W. H. Perkin, M.D., Junior Medical Assistant, St. Michael's Hospital; and A. J. Harrington, M. D., M.R.C.S., Eng., Toronto.

Clinical Medicine:
Alexander McPhedran, M.D., Professor of Medicine and Clinical Medicine, Toronto University; Physician, Toronto General Hospital; Lewellys F. Barker, M.D., Professor of Medicine, Johns Hopkins University, Baltimore, Md. H. B. Anderson, M.D., Toronto; Associate Professor of Clinical Medicine, University of Toronto.

Mental and Nervous Diseases:
N. H. Beemer, M.D., Mimico Insane Asylum; Campbell Meyers, M.D., M.R.C.S., L.R.C.P. (London, Eng.), Private Hospital, Deer Park, Toronto.

Gynecology and Obstetrics:
B. A. Watson, M.D., Edin., F.R.C.S., Edin., Professor of Gynecology and Obstetrics, University of Toronto; Gynecologist and Obstetrician, Toronto General Hospital; Geo T. McKeough, M.D., M.R.C.S., Eng., Chatham, Ont.; C. F. Moore, M.D., Toronto; and A. C. Hendrick, M.A., M.B., F.R.C.S. Edin., Demonstrator in Gynecology, University of Toronto; Assistant Gynecologist, Toronto General Hospital.

Pathology:
J. J. Macrenzie, B.A., M.B., Professor of Pathology and Bacteriology, University of Toronto; H. K. Detweiler, M.B., Assistant Pathological Dept., University of Toronto.

Ophthalmology:
J. M. MacCallum, M.D., Toronto, Senior Assistant Eye Department, Toronto General Hospital; Oculist and Aurist Victoria Hospital for Sick Children, Toronto. Walter W. Wright, M.B., Assistant in Ophthalmology, Toronto General Hospital and Hospital for Sick Children.

Nose, Throat and Ear:
Perry G. Goldsmith, M.D., 84 Carlton St., Toronto, Laryngologist and Aurist, Provincial Institution for the Deaf and Dumb; Senior Assistant Ear, Nose and Throat Department, Toronto General Hospital.

Dermatology:
D. King Smith, M.B., Tor., Toronto; Demonstrator in Pathology, Toronto General Hospital

Managing Editor:
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont.

Address all Communications, Correspondence, Books, Matter regarding Advertising, and make all Cheques, Drafts and Post-Office Orders payable to "The Canadian Journal of Medicine and Surgery," 145 College Street, Toronto, Canada.

Doctors will confer a favor by sending news, reports and papers of interest from any section of the country. Individual experience and theories are also solicited. Contributors must kindly remember that all papers, reports, correspondence, etc., *must be* in our hands by the first of the month previous to publication.

Reprints supplied at Net Cost

Society Proceedings

CANADIAN MEDICAL ASSOCIATION

The Quebec meeting was marked by some splendid features—among others, the address on "Laennec," a partial report of which follows herewith:

Dr. Thayer, in opening his address, spoke of the high regard he and his countrymen felt for Canada as a result of the war—she was surrounded in aureola which can never fade. Laennec was born in 1781 at Quimper in Lower Brittany. His father was a light and airy personage—a happy-go-lucky sort of person—a peculiar sort of father for so distinguished a son. Laennec had two uncles to whom he owed much. His mother died of consumption when he was five years of age. His father sent him to live with an uncle who was a doctor of the Sorbonne and rector of the parish of Elliant. Here he learned Greek thoroughly. This uncle being promoted to a canonry, young Laennec was placed under the charge of another uncle, Guillaume, professor of medicine at Nantes, and physician-in-chief to the Hotel Dieu in that city. This uncle had studied under John Hunter, of London. He completed his literary education at the École Central; was an enthusiastic Greek scholar, and could write and speak Latin fluently, translating one of Virgil's ecologues. At the age of twelve he also wrote verse. He devoted a good deal of time to the study of the Celtic dialects. He was also deeply interested in natural history; devoting himself to collecting specimens. He graduated from school in 1795. He was alert, active and ambitious. He was filled with a desire to perfect himself in riding, dancing and music. In 1798, he suffered from a serious illness—likely typhoid. For a time in 1799, although unqualified to practice he was attached to the medical department of the army, and

joined in a military expedition. He composed a long poem descriptive of this expedition. On his return he resumed his medical studies, the uncle having struggled long with the scatter-brained father to furnish funds to enable the boy to carry on his work. In 1800, at the age of nineteen, he entered the École de Medicine (University) of Paris, attaching himself to the clinics at the Charité, where he worked under Corvoisart, the great expounder of Auenbrugger's great work on percussion. "Each morning students were trained in the examination of patients and observations were completed by careful necropsical examinations." Lænnec was a marked student. Studied pathology under Bichat. He kept careful notes of all his observations. His assiduity was remarkable, and he showed a discrimination system in all that he did. He soon began to communicate his observations. His first three publications in 1802 related to (1) a case of diseased heart, (2) histories of inflammation of the peritoneum, and (3) a review of Bell's "Treatise on Venereal Disease." The second communication was epochal. The pathological aspects of the peritontides had been touched on by Bichat, but until Lænnec's studies had not been recognized clinically. These were the beginnings of a series of contributions to medicine equalled by few in the annals of medicine. In 1804, he took his degrees, his inaugural thesis being entitled "Propositions sur la Doctrine d'Hippocrate Appliquée à la Medicine Pratique." Bayle said of this essay that it proved him to be no less skilled in his knowledge of the Greek language than deeply read in the writings of the father of physic. In this thesis he says that medicine is not a new science; that the student should follow the paths of those who, through long years, have made many and valuable discoveries; and that everyone endowed with the necessary qualities, knowing that which has been done before, may start from this point, and if he follows the same road will make new contributions. But he who rejects the work of his predecessors and pursues his studies along another road and in another fashion and thinks he has found something, dishonors himself and dishonors others. Lænnec points out the necessity of classification of disease and the importance of diagnosis. In addition to the general symptoms, there were

special symptoms associated with each diseased process. The only method by which one can acquire solid knowledge depends on the adoption of no principle which is not proved by many separate facts. If we study with care the character and course of diseases, and treat them according to the indications drawn from observation of that which has succeeded—this is the method which Hippocrates asserts to have been fundamental long before him. Lænnec continuing, contends that medicine is free and that he places himself neither with the ancients nor the moderns, but follows the one party as well as the other when they cultivate the truth; yet more often he leaves himself free for independent observation. Wise advice for the day in which he lived; wise for all time, if not taken too literally. After graduation, for five years he conducted the *Journal de Médicine*, and for two years he lectured in pathological anatomy. In 1805 he published an article on pathological anatomy in which he sought to set forth the classification of organic changes—a valuable communication which led to long disputes with Dupuytren. He again became interested in the Celtic dialect of Lower Brittany. He gained a good knowledge of art. He contributed frequent critical reviews. He described in a summary the diseases prevailing in Paris. Already his hard work had told upon him seriously. His asthma disturbed him greatly. Rest he needed which he could not obtain. He took a vacation of several weeks in 1805 at Courcelle, which did much to strengthen him.

In 1812, he was appointed physician to the Beaujon Hospital; in 1814, to the Salpetriére. His knowledge of Gaelic was a great help to him in consoling young Breton conscripts, who were unable to make themselves understood and were homesick.

One day while traversing the Court of the Louvre, Lænnec is said to have seen some children playing about a long beam. One would place his ear at the end of the beam and listen, while another tapped lightly at the other end, the sound being well transmitted through the solid body. This gave to him the idea which led to the great discovery of his life—the stethoscope. Being consulted by a young, fat woman with symptoms of heart disease, he took a sheet of paper and made

a tightly rolled cylinder, one end of which he placed upon the precordial region; putting his ear to the other end, he was as much surprised as satisfied to hear the beats of the heart much more clearly and distinctly than he had ever heard them by the immediate application of the ear. This was followed by the use of a hollow wooden cylinder, which he made himself. A good deal had been discovered by Bichat as to the pathological changes produced by disease. But Lænnec had his eyes open for something more than could be learned by percussion, inspection, and mensuration. Within three years he brought before the world the character of respiration, the voice changes, etc., as clearly as taught to-day. He described anatomically and clinically the various forms of pulmonary troubles—emphysema, œdema, pneumonia, bronchitis, pleurisy, and tuberculosis.

With the advent of the stethoscope a recognition could be made of the minor points of disease. His contributions to disease of the heart were not on the same plane. The physiological explanation of the heart sounds and their significance were unknown at that time. Lænnec thought that the second sound was auricular in origin.

It was a great work for one man. How was it done? Lænnec tells us in the preface of his book: "When a patient enters the hospital it is the duty of a pupil to collect from him those anamnestic facts which he can give concerning his disease, and to follow their course. On examining the patient myself, I dictate the principal symptoms which I observe—those especially which may serve to establish the diagnosis or indications for treatment. And I confirm my conclusion, unless I may have to change it, by subsequent observations. This dictation, which is made in Latin for reasons easily appreciated, is taken down by the pupil in charge of the patient, and at the same time, on a separate sheet, which I call the diagnostic leaf, to keep which, in order that it may be shown me and read whenever required at each visit, is the especial duty of another pupil. If a new sign appear, such as might modify the first diagnosis, I have that also added. If a patient die, the account of the autopsy is collected by the pupil in charge of the case. I read the account before all those who

have been present at the autopsy, and if any correction is to be made, I make it on the spot, after having consulted with them."

Lænnec's visits lasted from an hour to an hour and a half. He invited his class to the necropsy and committed himself as to the changes he expected to find. There could be no better model for study and instruction. In May, 1816, he read a memoir upon the auscultation with the stethoscope, giving the first public demonstration of its use. In 1819—one hundred years ago—he published his work, "De l'Auscultation Mediate," in two volumes. Though seriously criticized by some, it was soon taken up by the world.

Lænnec was small and delicate in frame. He was spirited and devoted to out-door sports, especially hunting. Some of his rich patients gave him the run of their estates. During the winter he practised shooting in his apartments with an air-gun. Frail as he was, he was especially proud of his success in athletics of all sorts. Lænnec was but a breath of air, and he thought himself a Hercules. The vigor of his mind he placed in his muscles. He was burning the candle at both ends; and was probably suffering from the same disease which carried away Bichat, having developed an anatomical tubercle on his finger which persisted. Broken down, he retired to Brittany. He married his housekeeper. He roamed about and spent part of his leisure renewing his classical studies and the dialect of his people. Rest and change gradually brought new strength, and at the end of two years duty called him again to Paris. On his return he supplied the chair of Hallé at the Collége de France. At this time Broussais had raised a considerable stir by the promulgation of his "physiological doctrine"—which ascribed all of the vital processes to "irritation," particularly to heat, "which excites the chemical processes in the body. Disease, however, depends upon localized irritation of some viscus or organ, *e.g.*, the heart, or, above all, the stomach and intestines." All treatment was reduced to its simplest terms. Lænnec warned against the fallacy of the new doctrine; and he easily overcame this modern Paracelsus. His clinic was sought by doctors from all countries. In 1823, he became a member of the Academy

of Medicine, and in the next year he was made a Knight of the Legion of Honor. From 1824 he worked assiduously on the second edition of his treatise on the study by auscultation of the diseases of the chest. In this he changed the form entirely; he pursued the analytic method by giving the different sounds elicited by percussion and auscultation, with the corresponding anatomic findings. In the 2nd the method is synthetic, each disease being described in detail in respect of diagnosis, pathology and treatment, so that this edition is the most important treatise on disease of the thoracic organs that was ever written. This, with his many other duties and cares, was no light task, and his health began rapidly to fail. He completed the work, however, and then, in 1826, a physical wreck, advanced in pulmonary tuberculosis, he retired for the last time to his native Brittany. He was no exception to the common rule, and at the end declined to recognize in himself that which he would have been the first to discover in another. He died August 13th, 1828, at the age of forty-five. Two hours before death he removed his rings, saying: "Someone else will soon have to do this for me; I would save him trouble." Forty-five years! In ten years, since the discovery of auscultation, he had brought the art of physical diagnosis from a state of the utmost crudity almost to a point at which it remains today; also the introduction of a new method of the study and analysis and changes in organs themselves—not only by auscultation, but by every method then known. A model for all time.

Speaking of his observations, Laennec says he hopes he presented them in such a manner that one will not attach more importance to them than he himself; and that he would never give that which he thought or supposed his point of view as constituting true science; rather that which *he knows.*

That which he did for the lungs was later done by others for the heart.

The advance of medical science has increased rapidly in the domain of pathological anatomy and bacteriology, in physics, chemistry and in the application of electricity and the X-ray. By them we have been able to delve deeper into the nature and process of life and disease. They have augmented

our powers in the recognition and prevention and, in some instances, our powers in the relief of disease. Refinements of diagnosis and possibilities of treatment demand an increasing mass of knowledge and experience which we struggle often in vain—especially in the United States, to crowd in the initial period of our university training. All methods of research, no matter how valuable they may be, are only of use exercised by one mastering them by practice and experience. New methods in the hands of the inaccurate and inexperienced may be mild and harmless. All these refinements must be studied and practised carefully. Then their revelations are not final. They are but additions to our basic armamentaria; new bricks for the edifice of diagnosis and treatment. In the domain of diagnosis, the simple procedures of Laennec constitute the basic structure of our art. No man can profit by the modern refinements who has not experience with pathological anatomy, the changes in the diseased organs, and is not well trained in the fundamental methods of physical exploration—skilled in auscultation and percussion—a knowledge of the activities of the heart and lungs in health and disease. How variable these manifestations may be in the normal subject! The power to explore is to my mind a great part of the art. This familiarity, this training, this power is to be gained in the necropsy room and in the ward. Books cannot teach it; it cannot be learned in the lecture room. No magic power of inheritance can transmit it. Some things one can only transmit well by experience and practice. It is precisely these points, the training of students at the bedside and in the autopsy room—which must be emphasized. Nuances of râles; the distinction between deep and superficial phenomena, the friction sounds in pericarditis, the comparison of sounds and the process of exclusion, etc.

The experiences of the last few years make it painfully clear that a large proportion of our American physicians are lacking in the essential foundation of training in diagnostic methods. In the army it was observed that there was a tendency to act on information from the laboratory and to accept laboratory reports without considering them in relation to the clinical aspects of the situation. Unreliable reports

from laboratory sources are worse than useless. Findings in X-ray work, reports on sputum, excreta, bacterial cultures, agglutination test, complement deviation, etc., come back in short and definite reports.

Too often the X-ray reports have to the practitioner a sense of finality generally unjustified: to the physician not familiar with the clinical aspects, a danger: a trap into which he falls. If he cannot control the X-ray report, it is a liability rather than a help.

Dr. Thayer reported having seen a case in consultation—a man with cardiac disease and angina pectoris. The doctor in charge of the case was not familiar with the symptoms. He had had a radiologist take an X-ray. It showed the heart enlarged. Someone else had taken a Wassermann for him; it was negative. Someone else had given a test breakfast: no result. Urine? No abnormality; good. Any pain? Over the heart. Did it radiate to any other part of the body? No. Associated with exercise? The doctor thought not. After questioning, Dr. Thayer realized that the doctor had no information as to physical signs or symptoms; and spoke to the patient. In a few moments he learned that the pain followed exercise; that it did radiate into the arm in the characteristic manner of angina. . . . The doctor had neglected the ordinary methods of investigation; depending on the report and experience of others in this and that and the other detail. This is not to practice medicine. Though exaggerated, the above instance is the type of thing one meets too often in the examinations made by the younger as well as the older officers of our Army Medical Corps. In pneumonia cases, the Chief of Service discovers thirteen unrecognized empyemas in thirty-two patients—one hundred years after Lænnec's book!—discovers unrecognized pleural effusions which were regarded as unresolved pneumonias!

Who is to blame? Are the men incapable of acquiring the foundations of the art? No. On the contrary, in one of the United States army hospitals courses of instruction were inaugurated. Many medical officers, young and old, grasped the opportunity, and quickly acquired methods of physical ex-

amination which they had not been taught properly in the schools.

The general interest in bacteriological, serological, chemical methods in some schools has led us to forget the long and systematic training in the laboratory, ward and out-patient department, in pathological work, in physical diagnosis —particularly in auscultation and percussion. Training in diagnostic methods is useless if a man has had no experience in the dead-house. He must be familiar with alterations in the body. The teaching of auscultation and percussion must be carefully supervised and they must be understood. Instruction must be given in small groups. The student must be led to make his own discoveries—to solve the whole problem, directed to a proper course by reasoning. Physical diagnosis can be taught only at the bedside. And this instruction in physical diagnosis should not be relegated wholly to the young instructor. One of our most important duties is to give personal attention to the students when they begin this work; it exercises an important and lasting influence at this moment. Improper teaching lies at the root of the inefficiency of so many practitioners. If, instead of the bedside method, students are referred first to books or to listen to discourses on diagnostic methods, they become handicapped by preconceived ideas, the influence of which they may never overcome.

One should insist on familiarity with the normal. This is too often overlooked. No student should leave a medical school without studying with precision and care the atelectatic powers of the lungs. No man should practise medicine who has not made himself familiar by auscultation with the normal heart murmurs, especially the cardio-respiratory. They must know the normal first. The power to explore is a great part of the art. In epitomizing the life of Lænnec one would say that the kernel of the art of medicine lies in the power of exploration. And this can only be learned by experience and practice. The last century saw the perfecting of the art of diagnosis in many ways. The necessity of appreciating its importance is as vital to-day as it was one hundred years ago.

ONTARIO COLLEGE OF PHYSICIANS AND SURGEONS

The Council of the Ontario College of Physicians and Surgeons in session on June 25th discussed the findings of the Discipline Committee as regards the cases of several members of the profession against whom charges had been made. Of ten cases dealt with, nine were for breaches of the O.T.A., and most of them had already been dealt with by magistrates.

Members of the Council criticized freely the Ontario Government for having thrown this matter on the Council.

"The Government has made us an aggregation of bartenders and ought to supply us with white aprons," remarked one member. "I, for one, resent this treatment."

A question discussed at some length was whether because a doctor had appeared in a police court it was up to the committee to have him also appear before it.

The Discipline Committee apparently took the position that the doctors were not lending themselves to a traffic in liquor, as the reports on nine cases presented that morning were to the effect that the doctor was not guilty of the charge of breach of the O.T.A., and the Council confirmed the findings of the committee in each case. There was an occasional dissenting voice, one doctor remarking of a Toronto practitioner that he had so many people at his office that he had to hire a bouncer to keep them in line for prescriptions. This doctor in October last had issued 736 prescriptions.

The following doctors whose alleged breaches of the O.T.A. were reported were found not guilty by the Discipline Committee, who held in most cases that the prescriptions had been issued in good faith and in the belief that the patients required the liquor: Dr. Jas. Anderson, Hamilton; Dr. J. P. Rankin, Stratford; Dr. J. A. Bedard, North Bay; Dr. A. V. Mitchell, Toronto; Dr. G. A. Elliott, Toronto; Dr. W. B. Hopkins, Hamilton; Dr. J. A. Langrill, Hamilton; Dr. A. S. Langrill, Hamilton; Dr. A. B. Welford, Woodstock.

Dr. E. Brunet, Ottawa, was found not guilty on a charge of another character.

Seven cases remained to be dealt with in the afternoon.

Dr. A. T. Emerson occupied the President's chair ere the meeting closed.

The officers of the College for the coming year are: President, Dr. A. T. Emerson, Goderich; Vice-President, Dr. G. A. Rutledge, Lambeth; Registrar-Treasurer, Dr. H. Wilberforce Aikins; Counsel, H. S. Osler; Official Stenographer, Geo. Angus; Auditor, H. J. Welsh; Prosecutor, John Fyfe.

On June 26th the Council decided to erase from the rolls for breaches of the Ontario Temperance Act the names of Dr. H. H. Moorehouse, Toronto; Dr. A. Ruppert, Toronto; Dr. Percy Gardner, Dr. Raymond Rheaume and Dr. J. N. Cherniak, all of Windsor, and to suspend for three months Dr. E. F. Kelly, Toronto, and Dr. D. McEdwards, Hamilton.

The Council in the case of each of these practitioners confirmed the findings of the Discipline Committee, which had gone into the charges previously and heard the doctors in their defence.

MEDICAL COUNCIL OF CANADA MEETS

The Medical Council of Canada held its annual session in Ottawa in June.

Hon. Dr. Roche, Chancellor of Western University; Dr. L. del Harwood, Dean of Laval in Montreal, and Dr. N. E. McKay, of Halifax, took their seats for the first time this session. The Council is composed of 32 representatives, as provided for in the Act.

This year it was under the Presidency of Dr. R. E. Walker, of New Westminster.

One important matter of business was the decision of British Columbia to relinquish the local provincial examination for license in favor of the examinations as set by the Medical Council of Canada.

Another important matter was discussed, viz., the reintroduction into the Act of powers to negotiate with Great Britain and other countries, looking towards reciprocal acknowledgments of license.

Examinations were ordered in Montreal and Halifax in October, 1919, and in Toronto, Winnipeg and Vancouver in June, 1920, the object being to facilitate candidates taking the examination at as little expense as possible. The new President is Dr. J. C. Connell, the Dean of Queen's Medical Faculty. The Vice-President is Dr. McNeill, of Summerside, P.E.I. The Honorary President is again Sir Thomas Roddick, of Montreal. Dr. R. W. Powell, Ottawa, is Registrar, and F. H. Chrysler, K.C., of Ottawa, is General Counsel.

Selected Articles

RECALCIFICATION IN BATTLEFIELD DISEASES AND WOUNDS

(Translated from the Paris Progrès Medical.)

It is yet too soon to publish a complete study of recalcification in the treatment of wounds and diseases of the battlefield, but the clinical reports already collected enable us to give the details of the drug's action and again assert the therapeutic value of the recalcification method.

The Ferrier method has now been in use for nearly fifteen years and the employment of calcium salts has been accepted by the pharmacopeia. The earlier preparations were not retained by the tissues and were quickly eliminated and, as we know, lime salts must not only be ingested but must also be absorbed. It is generally known that Ferrier, after careful researches in dentistry and in phthisiotherapy, proved that the solubility of lime salts and the hyperacidity of the organism are the two principal causes of decalcification.

Recent investigations have proven the value of radiography in the study of pleuro-pulmonary calcification. It is especially useful in confirming the results obtained by medication.

Radiography, if the small diaphragm is used, will show a central intense coloration with clear-cut border and adhering tissue, without trace of pus in the intervening space, when Tricalcine has been administered for several days. This calcification indicates, as it were, a beginning cure.

When soluble salts are employed the assimilation of lime is questionable and the radiographic shadow is different, the borders are irregular and the central opaque spot is modified by the shadows, thus showing, without a doubt, the inefficiency

of the old-time lime salts and the newer preparations of soluble salts as well.

It should, however, be remembered that recalcification treatment is effective only in certain well-defined conditions. There must, first of all, be a perfect hygiene of the digestive system. Briefly, no superalimentation, suppression of acids, etc. Careful supervision and treatment is necessary of the liver. Use of lime-containing waters which aid digestion, such as Pougues-Alice Water. Physicians who have used the Tricalcine under these conditions are aware of its efficacy in the treatment of tuberculosis, asthenia, disorders of dentition and of the bones, and in pregnancy. It is a simple method and economical when dealing with long-lasting cases.

Although apparently there would be no indications for Tricalcine in the military hospitals, clinical notes have, since the beginning of the war, shown that this preparation has been used with success by the soldiers. This is explained by the fact that under the influence of a too-uniform or too-variable diet, of over-exertion, fatigue or privations and the trying ordeal to which the nervous system is subjected, our wounded and sick soldiers undergo a well-defined though more or less severe demineralization. This latter is so serious that in certain cases tuberculosis declares itself after the patient has been in the hospital a few weeks.

All army doctors have noticed the serious disadvantages of a prolonged stay in the hospital for sick and wounded soldiers from the front.

Systematic recalcification is indicated for the debilitated soldier upon his arrival at the hospital. Under this treatment tuberculosis may often be prevented and, at all events, the patient's condition usually improves rapidly and he is in better shape to return to the front. The best results have been obtained in the following cases:

1. Tuberculosis and well defined demineralization due to various causes.

2. Convalescence from disease.

3. Battlefield wounds of the bones.

That recalcification has proven its worth in tuberculosis has already been demonstrated. If the lung apex is only suspected

of being involved or is already involved recalcification medication should be employed to the full extent. The treatment is always indicated for debilitated patients, and there is no better means of preventing hasty tuberculosis due to too-sudden change of life and environments. In cases of asthenia fatigue and severe muscular pain, with or without altered breathing over the apices, Tricalcine should be prescribed, as it effects a gradual but well-defined improvement.

Herewith are a few clinical histories taken at random:

A. D., 10th Infantry Regiment, 36 years old, slight bronchitis, especially noticeable over the apex. Emaciation, depression, rise of temperature at night of from one-half to one degree Centigrade. After three weeks' treatment this soldier left the hospital on a month's convalescent furlough. As we have already stated, it is advisable to remove these patients from the crowded wards.

V. P., 21 years, 10th Squadron Wagon Train, Uncomplicated pleurisy. Treatment very effective.

R. N., 41 years old, 10th Territorial Regiment. Anemia. Suspicious bronchitis. Rapid improvement under recalcification treatment.

B. A., 29 years old, 10th Infantry Regiment. Dyspepsia. Anemia. Bronchitis: Tricalcine, Pougues Alice water. Diet. A nearly complete cure in 20 days.

B. L., 39 years old, 10th Infantry. Anemia. Fistula in ano. Owing to the probable origin of the fistula, recalcification treatment seemed to be distinctly indicated in this case, and it gave the best of results.

V. F., 21 years old, 10th Infantry Regiment. Suspicious bronchitis involving the left apex, general fatigue, anorexia. Excellent results from the treatment.

In all cases of convalescence from diseases contracted in the armies, Tricalcine has proven of great benefit, especially in diseases of the lungs and pleura, in digestive disorders, etc. It has been used systematically after typhoid fever, in the military hospitals. It was prescribed after examination for bacilli in the urine had given negative results, and convalescence progressed thereafter with unusual and evident rapidity.

F. J. M., 37 years old, 10th Territorial Regiment. Typhoid

fever of moderate severity with dry pleurisy. Was vaccinated twice. No serious complications. Bacteriological examinations of urine being negative, Tricalcine treatment, together with resumption of a carefully chosen diet, was followed by a daily improvement. Weight increased noticeably and there was a modification of the urinary phosphates as compared with that of the patients that were not subjected to recalcification medication. Complete cure assured in a few days.

D. H., 36 years old, 10th Territorial Regiment. Typhoid fever, ataxo-adynamic type. Intestinal hemorrhages, vomiting, severe relapses as soon as the bacilli disappear from the urine. Recalcification treatment is used with success.

The same interesting results were observed in other patients.

A similar improvement has followed the use of this form of treatment in convalescence from diphtheria, concussion of the brain with or without otitis due to indirect traumatism.

In battlefield wounds recalcification has proven very effective in the treatment of fractures, especially those caused by missiles. This is not astonishing when we consider the various factors which induce a condition of decalcification in the wounded. Tricalcine may be employed without restriction and with much benefit. In all cases consolidation is more rapid and the bone structure is much stronger.

To mention a few cases:

B. J., 33 years old, 10th Artillery Regiment. Fracture of the elbow by fragment of shell. Treatment lasted 25 days.

C. E., 32 years old, Colonial Foot Regiment. Fracture of the left radial bone by a rifle ball. Distinctly visible by radiography. Cured in 20 days. Leaves at his own request to return to the front.

C. H., 33 years old, 10th Infantry. Fracture of the right humeral bone by a rifle ball. Patient much depressed, rapid recovery.

L. A., 26 years old, 10th Infantry. Fracture of the right leg by shrapnel, which lodged in the interosseous space. Operated upon several times. Radiography showed several of the projectiles to be inaccessible. Well-defined improvement under treatment.

Summary.—Recalcification by means of Tricalcine has

given the best results in the three classes of wounded and sick soldiers just enumerated.

This medication should be prescribed for nearly all enfeebled patients, and especially for all those whose urine shows a demineralization greater than the normal average. Nine times out of ten the loss of phosphates exceeds this average.

Tricalcine is a practical medication, the benefit of which should not be denied to the wounded and sick soldiers.

Personals

MEDICAL GRADUATES OF THE UNIVERSITY OF TORONTO DECORATED, 1914-1918

K.C.V.O.—Lieut.-Col. Sir E. S. Worthington.

C.B.—Col. A. Primrose, Col. J. A. Roberts.

C.M.G.—Lieut.-Col. J. A. Amyot, Col. D. J. Armour, Lieut.-Col. E. C. Ashton, Major G. W. Badgerow, Surgeon-General J. T. Fotheringham, Col. G. G. Nasmith, Lieut.-Col. G. S. Rennie, Col. W. A. Scott, Col. A. E. Snell, Col. D. W. McPherson.

C.B.E.—Col. George D. Farmer.

O.B.E.—Major Harold Orr, Major Richard Raikes.

D.S.O.—Capt. G. W. Armstrong, Lieut.-Col. J. E. Davey, Lieut.-Col. J. J. Fraser, Major R. M. Goresline, Lieut.-Col. J. N. Gunn, Lieut.-Col. E. B. Hardy, Col. W. B. Hendry, Lieut.-Col. D. P. Kappele, Lieut.-Col. T. M. Leask, Major T. H. McKillip, Capt. G. A. McLarty, Col. A. E. Snell, Lieut.-Col. C. G. Thomson, Capt. H. G. Young.

M.C.—Capt. H. H. Argue, Capt. A. C. Armstrong, Capt. C. F. Atkinson, Capt. J. E. Barry, Capt. T. H. Bell, Major C. A. Briscoe (with bar), Capt. J. V. Brown, Capt. H. Buck, Capt. A. A. Campbell, Capt. L. A. Carr, Capt. J. P. S.

*Killed in action or died on service.

Cathcart, Lieut. J. R. L. Christian, Capt. R. C. Coatsworth, Capt. K. E. Cooke, Capt. W. G. Cosbie, *Capt. J. A. Cullum (with bar), Capt. H. C. Davis, Capt. O. J. Day (with bar), Capt. A. A. Drinnan, Capt. C. P. Fenwick, Capt. D. T. Fraser, Lieut. C. T. Galbraith, Capt. A. J. Gilchrist, Capt. W. C. Givens, Major G. G. Greer, Capt. M. E. Gorman, Capt. H. P. Hamilton, Capt. R. I. Harris (with bar), Capt. H. Hart, Capt. F. R. Hassard, Major A. K. Haywood, Capt. J. N. Humphrey (with bar), Major E. S. Jeffrey, Major H. B. Jeffs, Capt. A. C. Johnston, Capt. G. C. Kidd, Capt. J. G. Lee, Capt. J. C. McCullough, Capt. P. McGibbon, Capt. J. F. McLay, Capt. R. J. Manion, Capt. J. F. S. Marshall, Capt. V. H. K. Moorhouse, Capt. J. K. Mossman, Capt. A. G. Naismith, Capt. W. F. Nicholson, Capt. L. C. Palmer, Capt. A. A. Parker, *Capt. M. H. Paterson, Capt. W. E. Sinclair, Capt. V. F. Stock, Capt. C. G. Sutherland, Capt. A. E. Sutton, Major A. H. Taylor, Capt. R. H. Thomas, Capt. F. M. Walker, Capt. W. C. Walsh, Capt. D. A. Warren, Capt. W. L. Whittemore, Capt. C. S. Wynne, Capt. C. R. Young (with two bars).

French Legion of Honor.—Lieut.-Col. H. R. Casgrain.

French Croix de Guerre.—Capt. W. H. K. Anderson, Capt. A. C. Armstrong, *Capt. J. A. Cullum, Capt. J. F. McLay, Col. A. E. Snell.

Belgian Croix de Guerre.—Lieut.-Col. J. H. Wood.

Serbian Order of St. Savva.—Major W. H. G. Aspland. Col. H. G. Barrie, Capt. J. K. Mossman, Capt. H. J. Shields.

Serbian Red Cross Medal.—Col. H. G. Barrie.

1914 Star.—Lieut.-Col. H. C. S. Elliot, Lieut.-Col. R. S. Pentecost.

Russian St. George's Medal and Order of St. Vladimir.—Major W. H. G. Aspland.

Mentioned in Despatches or for "Valuable Services."—Lieut.-Col. J. A. Amyot, Capt. R. S. Armour, Capt. G. W. Armstrong, Col. E. C. Ashton, Lieut.-Col. G. W. Badgerow, Capt. J. E. Barry, Capt. T. H. Bell, Lieut.-Col. P. G. Brown, Capt. H. Buck, Col. H. A. Bruce, Major F. S. Burke, Major H. H. Burnham, Col. I. H. Cameron, Lieut.-Col. H. R. Casgrain, Lieut.-Col. G. Chambers, Lieut.-Col. D. A. Clark,

*Killed in action or died on service.

Capt. W. A. Clarke, Major D. J. Cochrane, Capt. G. M. Dale, Lieut.-Col. J. E. Davey, Major A. W. M. Ellis, Surgeon-General J. T. Fotheringham, Lieut.-Col. J. J. Fraser, Capt. A. J. Gilchrist, Major D. A. L. Graham, *Capt. T. F. Graham, Capt. C. G. Gunn, Major P. G. Goldsmith, Major G. G. Greer, Lieut.-Col. J. N. Gunn, Lieut.-Col. E. B. Hardy, Capt. F. R. Hassard, Major A. K. Haywood, Col. W. B. Hendry, Major W. L. Hutton, Lieut.-Col. L. E. W. Irving, Major H. B. Jeffs, Lieut.-Col. T. M. Leask, Capt. A. R. Lindsay, Capt. R. R. McClenahan, Major S. H. McCoy, Major T. H. McKillip, Lieut.-Col. W. T. M. McKinnon, Major G. H. McLaren, Capt. G. A. McLarty, Col. D. W. McPherson, Lieut.-Col. C. S. McVicar, Capt. A. F. Mavety, *Lieut.-Col. H. H. Moshier, Col. G. G. Nasmith, Lieut.-Col. K. D. Panton, Capt. L. A. C. Panton, Col. H. C. Parsons, Lieut.-Col. G. R. Philp, Col. A. Primrose, Capt. G. W. Racey, Capt. J. A. Reid, Lieut.-Col. G. S. Rennie, Capt. W. A. Richardson, Major D. E. Robertson, Lieut. A. E. Ross, Col. J. A. Roberts, Lieut.-Col. E. R. Selby, Col. A. E. Snell, Major G. S. Strathy, Capt. S. J. Streight, Lieut.-Col. D. M. Sutherland, Major C. W. Waldron, Capt W. C. Walsh, Capt. D. E. S. Wishart, Lieut.-Col. Sir E. S. Worthington, Lieut.-Col. T. W. H. Young, Capt. H. G. Young, Lieut.-Col. O. A. Cannon.

Dr. F. N. G. Starr, Dr. Wm. Goldie, Dr. J. G. Fitzgerald returned to Toronto on Feb. 26th, after being overseas for six months.

Capt. Frederick Grant Banting, of Alliston, Ont., who took his M.B. in 1916, at the University of Toronto, after attending Victoria College with Class '14, was wounded early in October while serving with the 15th Field Ambulance, C.A.M.C. He returned to Canada early in March.

Capt. Charles T. Lewis, of Windsor, joined the C.A.M.C. immediately after graduating from the Medical College in 1916. After serving for a time with the 8th Field Ambulance, he received an appointment as M.O. to the 10th Brigade, C.F.A.

*Killed in action or died on service.

Dr. H. M. Speechly, who has been working in England for the past two or three years, returned to Canada in April. Dr. Speechly went overseas with the intention of relieving younger doctors for service at the front, and carried out his intention with the greatest diligence.

Major A. J. Gilchrist, M.C., O.B.E., of 455 Palmerston Boulevard, who recently returned, was in London, Eng., when war was declared, and he immediately signed up for service, becoming medical officer to the 1st Worcestershire Regiment, which reached France in October, 1914, taking over front line work after the retreat from Mons. He was forced to leave his battalion fifteen months later, owing to a broken knee. When convalescent he was appointed to No. 10 General Hospital at Rouen, where he was in charge of surgery until he left for home.

He was mentioned in despatches for work during the battle of Neuve Chappelle, and again later in the summer of 1915, being gazetted the Military Cross in January, 1916, and receiving this decoration at Buckingham Palace just before leaving for home. In the last King's Birthday honors he received the Order of the British Empire for work done at the Base Hospital. Major Gilchrist expects to take up practice in Toronto.

Two Toronto physicians, who are well known among the medical profession, have been recognized for war services, Col. Perry G. Goldsmith and Lt.-Col. Cooper Cole. Col. Goldsmith is appointed a Commander of the Order of the British Empire. While he went overseas with the First Canadian Contingent, he reached France ahead of it as a specialist in a British hospital. In August, 1917, he was mentioned in despatches and was later appointed President of the Standing Medical Board in England. Dr. Goldsmith formerly resided on Carlton Street. Lt.-Col. Cole, who is named an officer of the Order of the British Empire, is now the officer Commanding Whitby Hospital. Col. Cole went overseas with the C.A.M.C. in 1914, and was wounded. Upon his recovery he was given a position upon the London Medical Board, and later attached to Bramshott Hospital. His Toronto home is at 103 Gloucester Street.

The Physician's Library

Politics and the Canadian Army Medical Corps. By Herbert A. Bruce, M.D., F.R.C.S., Eng., Colonel, British Army Medical Service and C.A.M.C., Associate Professor of Clinical Surgery, University of Toronto, Surgeon, Toronto General Hospital. William Briggs, Toronto, 1919.

The publication of this interesting and amazing official correspondence in book form is epochal in that it places on public record a permanent history of petty jealousy, intrigue and autocracy that would otherwise never have reached the light. The book has already been reviewed generally in the public press, so that detailed comment is hardly necessary. Dr. Bruce deserves hearty commendation in that he has taken the public into his confidence in this manner, and incidentally reveals to what degree militarism of the bitterest and most autocratic type is permitted in the C.A.M.S.

The report Dr. Bruce was called upon to make was frank and sweeping, noting many abuses and advocating many desirable and urgent changes in the C.A.M.S. overseas service. He did the work that, as Inspector-General, he was appointed to do, thoroughly and without favor, with the expectation that it would be considered confidential by the Canadian Government. That it was made public in Canada was not intended by him, and was certainly unfortunate as it now appears for the Government and the heads of the C.A.M.S. His points were, in our opinion, well taken and his criticisms justified. This was proven by the fact that his suggestions and the initial reform inaugurated by him were largely carried out after his removal from office.

Unfortunately, and of necessity Dr. Bruce's report reflected upon the administration of the heads of the C.A.M.S.; and the

jealousy aroused and petty persecution henceforth extended to him and his confreres makes sorry reading for the profession.

The book, clear in type, and well bound, is an altogether readable volume, ably prefaced by the well-known writer, Hector Charlesworth. It gives in full measure the much-discussed Bruce Report and Baptie Report, the author's correspondence with Sir George Perley, Sir Robert Borden and other officials, together with the amazing account of the deliberate degrading of one of his committee, Lieut.-Colonel Wilson, and the treatment meted out to two other young medical men presumed to be the proteges of the eminent surgeon.

The book is a woeful comment on human nature set in autocratic places, and without doubt sets the reader querying what might be revealed of inefficiency and intrigue in other services were other appointees in the Government service as fearless and frank as Dr. Bruce.

CANADA PERMANENT BONDS A LEGALLY-AUTHORIZED INVESTMENT FOR TRUST BONDS*

WHETHER true or not, it is generally considered that in the past physicians have not been nearly as discriminating as they should have been in the selection of their investments. It is about time for the hard-working doctor to turn over a new leaf and tuck away a little each year by investing in some legitimate security that can be consigned to the family safe and forgotten, without another thought as to whether or not the interest will be paid. Why not select Canada Permanent Bonds for the following reasons:

1. The security is absolute.
2. The rate of interest is most attractive.
3. At maturity Bonds may be renewed without charge at the then current rate.
4. Canada Permanent Bonds are a legally authorized investment for Trust funds.
5. The Canada Permanent Mortgage Corporation is purely an investment company, in no sense a speculative institution.

* Publishers' Department.

IODINE IN SURGERY*

Modern surgery, stripped of its technical and operative details, centres about an attempt to exclude septic micro-organisms from wounds, and to destroy those organisms found in septic wounds.

The ordinary surgical antiseptic—an alcoholic solution of certain essential oils, fortified with phenol—has some power to destroy germ life in the test tube, but in such dilution as is adapted to application to incised wounds it has failed to successfully compete with sterilized saline solution; carbolic acid and corrosive sublimate are rapidly passing from use in surgical work.

Iodine, admittedly the most effective of antiseptics, has been inexpedient to use, because of its corrosive action upon raw tissue, as well as by reason of its coagulation of proteids and formation of an insoluble compound.

Iodex (Ungt. Iodi. M. & J.) has frequently been shown to be devoid of irritation properties, while exhibiting the full germicidal power of free iodine. It is to be hoped that surgeons who are unacquainted with the product will prove this for themselves by test.

There is a wonderful future for Iodex in surgical practice; its possibilities are far-reaching; its serviceability great.

Clinical reports in the possession of the manufacturers tell of septic abscess that was packed with gauze upon which Iodex was spread healing in one-third the usual time, and without pain at any stage; of an acute glandular abscess in the axilla, opened, scraped and packed with Iodex on gauze, entirely healed in 96 hours; of a septic hand, where pus formation involved the entire forearm, which was opened in many places for drainage, responding quickly to the innunction of a large quantity of Iodex over which a dry dressing was applied—temperature fell rapidly, granulation began to form at once and complete recovery without stiffness followed.

For local sterilization of the skin, Iodex, despite its fatty base, appears destined to supplant the solution of iodine that is now so widely used.

* Publisher's Department.

For lubrication of the examiner's or operator's hands, there can no longer be any question of the suitability and superiority of Iodex; a prominent surgeon has advised its use on the hands to facilitate the drawing on of rubber gloves.

Iodex may be used in septic cavities, such as the mastoid, to prevent contamination of the rest of the operation area; or in sterile cavities or wounds for the purpose of keeping them sterile.

Once convinced that no harm can arise from its use, the surgeon will discover a great many uses for Iodex that will save him much anxiety and trouble and prove of benefit to his patients.

OLEUM RICINI*

Castor Oil is one of the oldest drugs of which we have knowledge; indeed, the time of its first use is in the unrecorded darkness of antiquity, the oil being pressed from the Palma Christi bean, which grows in Greece, Egypt, West and South Africa, India, Polynesia, Tahiti, Samoa, Zanzibar, West Indies, Abyssinia, Nubia, Florida, Mexico, Paraguay, and Argentina.

Ol. Ricini has been put to many and varied uses—illumination, lubrication, food for silk worms, in paper-making, for leather dressing, in setting Turkey red dye, in sacrificial and other idolatrous rites, as an ointment, and as a laxative.

It was used as an ointment by the Egyptians a thousand years before Christ, and for the lighting of railroad trains in India as recently as 1895.

Rather an interesting drug this, taking into consideration its ancientness and wide range of usefulness to man. No other drug so long known is in present day use.

Significant of its utility and of man's appreciation of its worth is the fact that the world's production of castor oil increases from year to year, and is greater at the present time than at any other in history.

Nor is this uniform increase taken up in mechanical and

(*Continued on page xxxiv.*)

* Publisher's Department.

LISTERINE

A Non-Poisonous, Unirritating Antiseptic Solution

¶ Agreeable and satisfactory alike to the Patient, the Physician and the Nurse. Listerine has a wide field of usefulness, and its unvarying quality assures like results under like conditions.

¶ The Listerine formula is compatible with so many drugs in materia medica that it well answers the requirements of a vehicle or basic ingredient of many prescriptions.

¶ Listerine possesses a two-fold antiseptic effect. On evaporation, a film, consisting of boric and benzoic acid, with baptisia tinctoria remains on the surface to which Listerine has been applied.

¶ A small quantity of Listerine evaporated from a watch glass, or other suitable container, will disclose a residue of these beautiful crystals in abundance, as Listerine is a saturated solution of boric acid.

¶ May we send a bottle of Listerine to your address, Doctor, for your observation and use?

LAMBERT PHARMACAL COMPANY

2101 LOCUST STREET

SAINT LOUIS, MO., U.S.A.

66 Gerrard St. East **Toronto, Ontario**

M.S.—7

When writing advertisers, please mention The Canadian Journal of Medicine and Surgery.

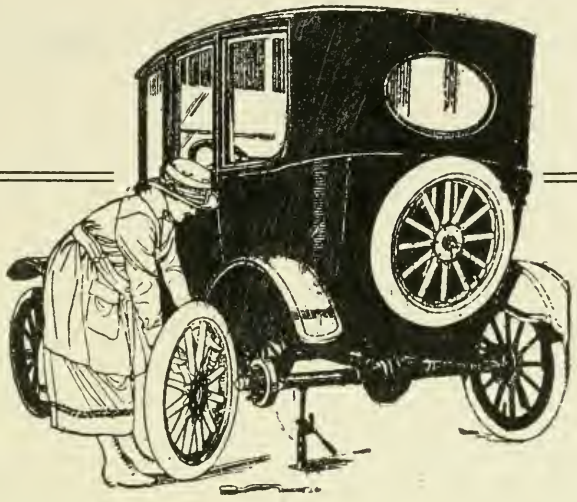
AN IDEAL RESORT FOR CONVALESCENT PATIENTS*

Physicians have frequent opportunities of referring those convalescing from illness to a resort where they can quickly recover their old-time vigor and enjoy an almost ideal climate, 2,500 feet above sea level. Such a resort is Virginia Hot Springs, just one night out of New York. The management have spent a huge sum of money on this choice spot in "Old Virginny," and are anxious that the Canadian medical profession should continue to refer cases there, as they have done in years gone by. The Homestead Hotel is one of the handsomest houses in America. It is built of solid brick, containing 500 guest rooms, with many parlor suites and 300 private baths. It is spacious, dignified, quiet and restful, with magnificent mountain views on every side. It is no exaggeration to say that Hot Springs means the Homestead Hotel. The Company owns 5,000 acres surrounding the hotel, so that physicians can understand that their patients have every opportunity of enjoying outdoor life and regaining thereby their normal strength.

The dominant factor making Hot Springs world-famous is the cure in which the climate as well as the water assist. The waters are conducted by gravity to the bathhouse and distributed fresh from the ground to the bathing apartments on different floors without loss of heat or its increase by artificial means, and fully charged with all their gases and other health-giving qualities. At none of the celebrated places in Europe, and at no other springs in America, is the temperature prescribed for hot baths that at which the water actually emerges from the earth in the natural springs.

The springs are beneficial, not only for bathing, but for drinking. Besides the hot springs, the effects of which as drinking waters are pronounced, there are magnesia, sulphur, and soda springs within the grounds, and alum water from a spring not far distant. The water from the soda spring comes strong and clear from the ground at a uniform temperature of 74 degrees. Physicians should address for full information Christian S. Andersen, Esq.

* Publisher's Department.



Equip Your Ford With Simplicity Demountable Wheels

Here is something new and **different** for owners of Ford passenger and commercial cars. Simplicity Demountable Wheels are just what you have been waiting for.

You use the same hubs as you are now using on your Ford car. All the changes necessary can be easily effected by your favorite Ford dealer.

Simplicity Demountable Wheels for Ford Cars

Eliminate all tire worries. Can be changed in less than 4 minutes, and so easily that a woman or a child can do it as quickly as a man.

Strengthen your car. Add no weight. Improve the appearance and give you a feeling of security and satisfaction in the knowledge that you do not have to run on a flat tire when you have a puncture or a blow-out. Simply jack up your car, loosen six nuts, remove wheel, slip on the spare and tighten the nuts—that's all.

PRICE for complete equipment with spare wheel, wheel carrier (side or rear), speed wrench, including installation....$30.00.

Call or write to-day for literature and full particulars, mentioning the name of your Ford dealer.

Simplicity Sales Co., Limited

Office and Service Station:
170 King St. West, Toronto

Factory: 119 Adelaide St. West, Toronto

PURE WHISKY FOR MEDICINAL PURPOSES

Doctor,—The following pronouncement of Dr. Milton L. Hersey, Provincial Government Analyst, will interest you, and goes to show that Corby's whisky is essentially suitable for use in the sick room.

Dr. Hersey writes:

"I hereby certify that I have conducted a careful chemical analysis of a sample of Rye Whisky marked 'Corby's Canadian Whisky,' distilled and in bond bottled by H. Corby Distillery Company, Limited, Corbyville, Ontario. I find it to be a pure whisky of excellent flavor, and can recommend it to those desiring a pure rye whisky."

Corby's Special Selected Whisky recognized as The Quality Whisky of Canada, is distilled from selected grain of the most desirable quality, and after distillation is rectified to remove the fusel oil, aldehydes and other deleterious matter. *Foreign whiskies are not rectified in this manner.*

SACRED HEART SANITARIUM

The attention of the Canadian medical profession is called to the advt., in this and subsequent issues, of Sacred Heart Sanitarium, Milwaukee, Wis. This institution has for years been conducted by Dr. S. S. Stack, who has a staff of nine or more assistants, each one a specialist in his own line. Particular attention is paid to laboratory work, and each case receives individual attention. Canadian practitioners who refer patients to Dr. Stack will be satisfied with the treatment accorded them.

RECTAL DISORDERS—THEIR SUCCESSFUL TREATMENT WITH DIOSAL SUPPOSITORIES

Diosal is the successful outcome of many efforts to produce a non-toxic, non-escharotic form of IODINE and RESORCIN combined for topical use in the treatment of mucous surface conditions. Most ointments are unsatisfactory because of transient effect, and continuous medication being necessary in the treatment of rectal lesions. In DIOSAL the iodine and resorcin is

GOLD

MEDAL

LONDON 1913.

THE NON-IRRITANT

LOCAL ANÆSTHETIC.

NOVOCAIN

Original GOLD MEDAL Brand.

DOES NOT CONTAIN COCAINE.

The original preparations as supplied by us for the past 12 years.

			Price
TABLETS	A.	For Infiltration Anaesthesia	60 cents
"	B.	For Conduction Anaesthesia	60 "
"	C.	For Spinal Anaesthesia	$1.10
POWDER in 1 gramme bottles			55 cents
5 gramme bottles			$2.40

THE SACCHARIN CORPORATION LTD.

Pharmaceutical Department,

36, 37, QUEEN STREET, CHEAPSIDE, LONDON, E.C.4.

Contractors to:-

WAR OFFICE.
INDIA OFFICE.
CROWN AGENTS for the COLONIES.

CANADIAN GOVERNMENT.
FRENCH GOVERNMENT.
BELGIAN GOVERNMENT.
ITALIAN GOVERNMENT.
ETC.

BRITISH RED CROSS SOCIETY.
FRENCH RED CROSS SOCIETY.
ETC.

Canadian Agent:- W. LLOYD WOOD · 64-66 GERRARD STREET EAST · TORONTO.

combined with a BISMUTH base which seems to solve the problem. DIOSAL also utilizes the characteristic adhesive action of a metallic hydroxide on a moist, mucous surface, providing continuous iodine and resorcin therapy over a lengthy period.

PULVOIDS NATRIUM COMPOUND

A HIGH BLOOD PRESSURE very often is a condition that may well alarm the careful physician, indicating, as it does, circulatory disturbances which must result in undue exertion and strain on the heart unless relieved; this being only one of the various serious results, Dr. M. C. Thrush has utilized a preparation which he designates as Natrium Compound, for the relief of conditions due to high blood pressure. The *Pulvoids Natrium Compound* (High Tension, Dr. M. C. Thrush) is marketed by the Drug Products Co., Inc., 48 W. 4th Street, N. Y. City. Samples and interesting and important literature to physicians asking therefor will be promptly furnished by R. L. Gibson, 88 Wellington St. W., Toronto.

GLYKERON

Glykeron and Glyco-Heroin (Smith) are synonymous appellations, and are now known as such to all dispensing pharmacists.

These names may now be used interchangeably by the physician when prescribing what was originally known only as Glyco-Heroin (Smith).

Glykeron is the more distinctive appellation and affords the physician a greater measure of protection against confusion on the part of the dispensing pharmacist when this preparation is prescribed for cough, bronchitis, pneumonia, phthisis, whooping-cough and kindred affections of the respiratory system.

AN EFFECTIVE COUNTER-IRRITANT

THE attention of the readers of THE CANADIAN JOURNAL OF MEDICINE AND SURGERY is called to the advertisements appearing on page xiii of this and subsequent issues, where the manufacturers of Kelpion make an interesting announcement. For many years this preparation has proved itself to be an effective counter-irritant and particularly suitable in the bronchial coughs of children. The company will appreciate physicians prescribing it when occasion offers.

The Canadian Journal of Medicine and Surgery

A Journal published monthly in the interests of Medicine and Surgery

Vol. XLVI. TORONTO, SEPTEMBER, 1919 No. 3

Editorials

ADOLESCENT CLINIC

Under the direction of Dr. Amelia Gates of San Francisco, the authorities of the Stanford University Medical School inaugurated a clinic for girls between 11 and 16. Dr. Gates reports her work with the first 100 girls in the April number of the *Archives of Pediatrics*. Under the care of the clinic there was an average annual gain in weight in each girl of 10.7 pounds—2 pounds above the Eastern average—which speaks well for California climate and living conditions. Dr. Gates, in treating the anemias, soon dropped giving iron and arsenic in favor of general hygienic measures. School strain affected menstruation adversely. She corroborates Beard wherein he says in his book on American Nervousness that nearly everything about the conduct of schools is wrong—unphysiological and unpsychological. Dr. Gates lays much stress on cleanliness during this

monthly period, and *exacts complete rest in bed the first day and rest after school for the succeeding two.*

Twenty-six of the girls had enlarged thyroids; 27 per cent. had round shoulders or had scolioses; 12 cases of enuresis (one of which showed an idiosyncracy to belladonna, even in a small dose); 5 had heart disease; 8, rheumatism; 2, pulmonary tuberculosis; 2, lues; 5, epilepsy; 4, chorea; headache, not due to eye-strain, 35 per cent.; constipation, 19 per cent. On the whole the condition of the throats was satisfactory. Seventy-one per cent. showed a retarded mentality by the Binet-Simm test; less by the point scale. Twenty-two per cent. belonged to the neurotic type, due, largely, to mental irritation at home or at school. Mothers and teachers are constantly admonished by the clinic, "Don't nag the child."

The girls find in the members of the clinic guides, philosophers and friends.

Every medical school, hospital and health centre might with great advantage to our girls—the future mothers of the race—establish such pre-eminently satisfactory clinics as this in San Francisco.

DISEASED IMMIGRANTS

CANADA has been the dumping ground for thousands of undesirable immigrants—from the slums of the big British cities, from Austria, Poland and other European countries. She is also the victim of colonies of sects who refuse to become assimilated—to become Canadian. This must stop. Our asylums

and jails are over-full of degenerates, criminals, and mental defectives. Our Government has been lax in her inspection of these multitudes who have been brought by the propaganda of big steamship companies, and great railroad companies and by our Immigration and Colonization Departments to our shores. The medical men appointed at our ports of entry have been too few, have been inefficient and underpaid. Under the old Government three part-time men at Quebec did the work of inspection at $1,000 per year. With the new Government these men were supplanted by a half dozen politicians who divide up the $3,000 among them! And these men examine the immigrants at the rate of one every ten seconds on their busy days! And this work is often done after 5 p.m., or early in the morning, when the light is bad, and urged to speed by the captains who find it very costly to hold their boats for any length of time at Quebec.

The strings must be tightened. These immigrants should be examined on the other side and be possessed of a clean bill of health before embarking for Canada. It costs us three to four thousand dollars to look after a case of insanity; one mental defect allowed to enter has cost the country half a million dollars.

Our profession should awaken to the paramount importance of seeing that our fair country is stocked with only the best; and should urge vehemently upon the powers that be the necessity of a thorough inspection of all new-comers.

We suppose this is one of the matters which will come under the purview of the new Ministry of Health. This immigration problem ought to receive immediate attention by the new bureau.

FUTURE OF MEDICINE

SINAPIS, whose *nom de plume* is a fitting one, on account of his smart paragraphs in *The Medical Press*, says if ever there was a time at which it behooved the medical profession to organize in defence of its own interests—even of its existence—it is now. He remarks thus in view of the first resolution summarizing the general after-war policy of the labor party:

"That the task of social reconstruction to be organized and undertaken by the Government, in conjunction with the local authorities, ought to be regarded as involving not any patchwork gerrymandering of the anarchic individualism and profiteering of the competitive capitalism of pre-war time—the breakdown of which even from the standpoint of productive efficiency the war has so glaringly revealed—but the gradual building up of a new social order, based not on internecine conflict, inequality of riches and dominion over subject classes, subject races, or a subject sex, but on the deliberately planned co-operation in production and distribution, the systematic approach to a healthy equality, the widest possible participation in power, both economic and political, and the general con-

sciousness of consent which characterize a true democracy.

Sinapis holds that a new social order of this nature cannot be established, nor begin to be established, without profoundly affecting the existing scheme of things in every class of the community. That the medical profession will not be left where it is, is one thing certain. The time has come, he says, for us to gird up our loins and place ourselves in a position effectively to talk with the enemy within the gate. The profession must organize; and until it has done so, its members are living in a fools' paradise.

Sinapis then goes on to say that the present medical organizations in Great Britain, such as the Royal societies (which he pokes fun at) and the other strictly medical societies, do not fill the bill. The National Medical Guild, a medical trade union, had become inept since the death of its dynamo, Doctor Raiment. The present hope was in the Panel Medico-Political Union, an organization of medical men embracing not only Panel but non-Panel men as well.

Canadian Journal of Medicine and Surgery

Editors

Surgery:
N. A. POWELL, M.D., C.M., Professor of Medical Jurisprudence, Medical Department, University of Toronto; Senior Assistant Surgeon in charge, Shield's Emergency Hospital.

Clinical Surgery:
ALEX. PRIMROSE, M.B., C.M., Edinburgh University; Associate Professor of Clinical Surgery, Toronto University; Secretary Medical Faculty, Toronto University; Surgeon Toronto General Hospital; and HERBERT A. BRUCE, M.D., F.R.C.S., Eng., Surgeon, Toronto General Hospital.

Orthopedic Surgery:
W. E. GALLIE, M.D., Associate Surgeon, Hospital for Sick Children, Toronto; CLARENCE L. STARR, M.B., Associate Professor of Clinical Surgery, University of Toronto; Surgeon-in-Chief of the Hospital for Sick Children, Toronto; Consulting Surgeon to Toronto General Hospital; H. P. H. GALLOWAY, M.D., Orthopedic Surgeon, Winnipeg General Hospital; Lecturer in Orthopedic Surgery, Manitoba Medical College; Member of The American Orthopedic Association.

Militia and Naval Medical Services and Ambulance:
J. T. FOTHERINGHAM, M.D.; C.M.G.; Colonel, Army Medical Corps, Associate Professor of Medicine and Clinical Medicine, University of Toronto; Associate Collaborator, CHAS. J. COPP, M.D., C.M., Hon. Sec. Provincial Council of Ontario, St. John Ambulance Association.

Medical Jurisprudence and Toxicology:
ARTHUR JUKES JOHNSON, M.B., M.R.C.S. Eng., Coroner for the City of Toronto; Surgeon Toronto Railway Co., Toronto; W. A. YOUNG, M.D., L.R.C.P., Lond., Ex-President of the American Medical Editors' Association; Associate Coroner, City of Toronto.

Hospital Administration:
MRS. AMY A. ARMOUR SMITH, R.N., New Rochelle, N.Y., Ex-Superintendent, New Rochelle Hospital, New Rochelle, N.Y.; A. K. HAYWOOD, M.B., Toronto, M.R.C.S., L.R.C.P., London, Medical Superintendent Montreal General Hospital.

Pediatrics:
ALLEN BAINES, M.D., Toronto; Associate Professor Pediatrics, University of Toronto; Physician, Hospital for Sick Children; HELEN MACMURCHY, M.D., Toronto.

Medicine:
W. J. WILSON, M.D., Toronto, Physician, Toronto Western Hospital; J. H. ELLIOTT, M.D., Associate Medicine and Clinical Medicine, University of Toronto; W. H. PEPLER, M.D., Junior Medical Assistant, St. Michael's Hospital; and A. J. HARRINGTON, M. D., M.R.C.S., Eng., Toronto.

Clinical Medicine:
ALEXANDER MCPHEDRAN, M.D., Professor of Medicine and Clinical Medicine, Toronto University; Physician, Toronto General Hospital; LEWELLYS F. BARKER, M.D., Professor of Medicine, Johns Hopkins University, Baltimore, Md. H. B. ANDERSON, M.D., Toronto; Associate Professor of Clinical Medicine, University of Toronto.

Mental and Nervous Diseases:
N. H. BEEMER, M.D., Mimico Insane Asylum; CAMPBELL MEYERS, M.D., M.R.C.S., L.R.C.P. (London, Eng.), Private Hospital, Deer Park, Toronto.

Gynecology and Obstetrics:
B. A. WATSON, M.D., Edin., F.R.C.S., Edin., Professor of Gynecology and Obstetrics, University of Toronto; Gynecologist and Obstetrician, Toronto General Hospital; GEO T. MCKEOUGH, M.D., M.R.C.S., Eng., Chatham, Ont.; C. F. MOORE, M.D., Toronto; and A. C. HENDRICK, M.A., M.B., F.R.C.S. Edin., Demonstrator in Gynecology, University of Toronto; Assistant Gynecologist, Toronto General Hospital.

Pathology:
J. J. MACKENZIE, B.A., M.B., Professor of Pathology and Bacteriology, University of Toronto; H. K. DETWEILER, M.B., Assistant Pathological Dept., University of Toronto.

Ophthalmology:
J. M. MACCALLUM, M.D., Toronto, Senior Assistant Eye Department, Toronto General Hospital; Oculist and Aurist Victoria Hospital for Sick Children, Toronto. Walter W. Wright, M.B., Assistant in Ophthalmology, Toronto General Hospital and Hospital for Sick Children.

Nose, Throat and Ear:
PERRY G. GOLDSMITH, M.D., 84 Carlton St., Toronto, Laryngologist and Aurist, Provincial Institution for the Deaf and Dumb; Senior Assistant Ear, Nose and Throat Department, Toronto General Hospital.

Dermatology:
D. KING SMITH, M.B., Tor., Toronto; Demonstrator in Pathology, Toronto General Hospital

Managing Editor:
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont.

Address all Communications, Correspondence, Books, Matter regarding Advertising, and make all Cheques, Drafts and Post-Office Orders payable to "The Canadian Journal of Medicine and Surgery," 145 College Street, Toronto, Canada.

Doctors will confer a favor by sending news, reports and papers of interest from any section of the country. Individual experience and theories are also solicited. Contributors must kindly remember that all papers, reports, correspondence, etc., *must be* in our hands by the first of the month previous to publication.

Reprints supplied at Net Cost

Original Contributions

CLINICAL OBSERVATIONS ON THE EARLY STAGES OF TRENCH NEPHRITIS

By Major G. S. Strathy, C.A.M.C
No. 16 Canadian General (Ontario) Hospital.

In the last three years many reports on epidemic or trench nephritis have appeared in the medical literature; but as most of them have been written by medical officers who have observed the disease in base or home hospitals, they describe only the more severe cases and the later stages of the disease. In a year at this C.C.S. about 300 patients were admitted suffering from this disease, and 205 patients were admitted between December 1 and June 1. The fact that patients in the earlier stages present a rather different clinical picture is the excuse for publishing this paper.

Epidemic nephritis is an affection which in most cases primarily affects the respiratory system, giving rise to cough, dyspnea, and sometimes sore throat. Symptoms due to affection of the urinary system usually arise later. When the kidneys are attacked most of the symptoms of the nephritis of civil life occur, but toxic symptoms are comparatively rare during their stay in a C.C.S. When the kidneys are mildly affected it gives rise to albuminuria with few subjective symptoms. When the lower part of the urinary tract is attacked hematuria is produced.

Not infrequently the lungs and pleurae bear the brunt of the attack, and the disease is characterized by respiratory rather than by kidney symptoms. In these cases bronchiolitis is usually marked, and hydrothorax develops in greater amount than

is accounted for by diseases of the kidney; and with no edema elsewhere in the body the pleural cavities may contain large quantities of fluid. According to Major Dunn (1), R.A.M.C., the characteristic lesion present is a proliferative endarteritis of the small vessels. This is most marked in the lungs, brain, and kidneys, and may lead to multiple minute thromboses and embolism.

Etiology.—Although microbic infection is almost certainly the cause of the disease, predisposing causes probably play an important part. The disease is non-existent in troops before landing in France or other theatres of war, and is not present in the civilian population at home, nor have I heard of it amongst the civilians in France and Belgium. It would therefore appear as if there is some great predisposing factor in the life of the army abroad, which prepares the way for infection. It is striking that cases have not broken out in England due to infection from returned soldiers.

The problem of the predisposing cause has given rise to many theories and suppositions. The epidemic is more prevalent on the Western European front than the other fronts, but occurs to some extent on all fronts. It is more common amongst the British troops than the French. It occurs amongst all arms of the service at the front, and is not unknown amongst troops at the base. We had two cases in the personnel of eighty-five of this C.C.S. while we were four months in Boulogne. McLeod and Ameuille (2) found that albuminuria occurred in a high percentage of troops in training in England. They found that the percentage of men having albuminuria was higher amongst British than French troops. The urea excretion was also higher amongst the British.

Various theories have been advanced to explain these facts. Exposure and fatigue due to army life were suggested as the cause of so many men having albuminuria. Chlorinated water and immature beer were said to damage the kidneys. I have found nothing to suggest that they were predisposing causes of epidemic nephritis. Several men were affected, who were sleeping in warm, dry billets, and did not do any heavy manual labor. Possibly the high protein diet of the British soldier

predisposes him to attack. Of 300 cases admitted to this C.C.S. only two were officers, and they had very mild attacks. One of them was from the Royal Flying Corps and was living in comfortable quarters. My records do not show age as a predisposing factor. Very few men were attacked during their first three months in France. Several Australians developed their first symptoms while on board ship coming from Egypt.

While there is probably some relationship between epidemic nephritis and the high percentage of albuminuria found in healthy troops both in France and England, it is almost certain that these cases of unexplained albuminuria are not mild cases of epidemic nephritis. It would seem likely that there is an extra strain thrown on the kidneys of the British troops which predisposes them to attack by a micro-organism which is prevalent in the army abroad.

Symptomatology.—The symptoms divide the disease into three main clinical types, namely (1), mild cases with albuminuria and few subjective symptoms, (2) hematuria cases with symptoms pointing to affection of the lower part of the urinary tract, and (3) nephritis cases with edema. These three main types cannot always be sharply differentiated for mild, or albuminuria, cases may go on to the more marked type with edema, or hematuria and edema may be present in the same patient.

(1) It is often difficult to differentiate mild cases of epidemic nephritis from albuminuria due to other causes. Captain Dixon, R.A.M.C.(T.), working in a divisional rest station near this C.C.S., found albumin in the urine of over 20 per cent. of all patients admitted.

Various fevers and chronic infections of the urethra or bladder accounted for but a small proportion of this high incidence of albuminuria. The remainder of the 20 per cent. must be put down to the unknown factor in service which causes albumin in the urine. In many mild cases of epidemic nephritis there is no demonstrable edema, and albuminuria is the main objective symptom. In even these mild cases of the disease, however, there is usually initial cough, dyspnea, dizziness, and pain in the back, while the cases of albuminuria due

to the unknown factor in active service have no subjective symptoms. The test on which most reliance is to be placed in differentiating these two conditions is blood-pressure. Nearly all cases of mild nephritis, even without edema, have an increased blood-pressure in the early stages. Few, if any, of the other albuminurias have increased blood-pressure. I have records of the blood-pressure of several hundred soldiers in France, and have found that apart from cases of nephritis or cardio-vascular diseases the blood-pressure of the British soldier when at rest is remarkably constant. A diastolic blood-pressure above 85 or a systolic pressure above 130 mm. Hg. is very rare in healthy soldiers under 35 years of age.

The following is a typical history of this type of nephritis. One of our operating room orderlies developed rhinitis, sore throat, hoarseness, and slight fever. He remained on duty, and twelve days later these had almost disappeared, but his face became edematous, his urine showed a considerable amount of albumin, his temperature was 99 deg. F., and his systolic blood-pressure 140. After rest in bed for forty-eight hours all his symptoms, except slight albuminuria, had disappeared. In a month he was normal.

(2) The second type—hematuria—is a smaller class. In six months twenty-two patients were admitted to this C.C.S. diagnosed as hematuria. Most of these were cases of hematuria without edema, for had all the patients with blood-stained urine been sent in as hematuria, the numbers would have been much larger, and if all patients with red bood cells in the urine had been so diagnosed nearly every case of nephritis would have had to be included, for, microscopically examined, the urine of nearly all patients with moderate or severe nephritis showed the presence of red blood cells.

Under the name of hematuria, then, I include only those cases in which hematuria was marked and there was no edema. These patients' most marked symptoms were referable to the lower urinary tract, that is, kidney pelves, ureters, and bladder. Pain in the lumbar region and flanks was usual. Pain over the bladder was not uncommon, frequency of micturition was the rule, and tenderness on deep palpation in the hypogastrium

present in a few cases. Fever was often high. The blood-stained color of the urine disappeared in a few days. Rise of blood-pressure was not always present and was never marked.

(3) The third clinical type comprising those usually sent to C.C.S. diagnosed as nephritis or bronchitis is the most important, for it includes all the severe cases. This type resembles in most respects the acute nephritis of civil life, but shows important differences. Bronchitis, edema, hydrothorax, and ascites are more marked features than are toxic symptoms, such as headache, drowsiness, vomiting, and convulsions. The lack of symptoms due to cerebral poisoning by chemical products is an outstanding feature in over 90 per cent. of the cases. Convulsions occurred in only five of our cases, yet many patients were in danger from the bronchitis and the mechanical effects of fluid in the thorax. Suppression of urine is seldom marked. There are really less than 15 oz. in twenty-four hours. Rapid disappearance of acute symptoms is usual.

Edema was one of the earliest symptoms in 30 per cent. of the cases of a severe type. Cough and dyspnea were the first symptoms present in 72 per cent. of cases, and diarrhea was the earliest symptom in 10 per cent. In many cases the patients had cough and dyspnea for several days, and in some cases for three weeks, before edema appeared. Patients were seldom sent to hospital befor the edematous stage.

Nearly all the severe cases admitted were markedly dyspneic due to bronchitis and fluid in the pleural sacs. *This marked tendency to affection of the lungs and pleurae, and the unequal distribution of edema in the body, is the most outstanding feature of the disease in contrast to nephritis of civil life.* So much is this so, that one doubts if the disease should be described as a nephritis, but rather as a proliferative endarteritis of the smaller vessels affecting different organs with varying severity in different cases.

Case No. 467 illustrates this severe type of lung infection. Pte. G., aged 25, gave a history of not feeling well for ten days. He had had slight edema of the face and feet, shortness of breath, headache, and severe pains in the back. He was on duty until the day before admission. Admitted at 2 p.m., he

was markedly dyspneic, had much edema of the head, but little elsewhere. Dry persistent cough, which was not relieved by morphia gr. ⅛. He died in nine hours.

At post-mortem there was an acute bronchiolitis with about 40 oz. of fluid in the right pleural cavity, about 30 oz. in the left, and only 8 oz. in the peritoneal cavity. Liver and spleen were much enlarged. Kidneys were not swollen, slight congestion around pyramids, pale elsewhere. The spleen showed many minute hemorrhages. This patient died from lack of gaseous exchange in his lungs.

Edema of the face was present in all cases except one, and he gave a history of slight swelling of the face prior to admission. This patient died without edema appearing anywhere, and post-mortem showed marked hydrothorax and very little ascites. A striking feature was lack of edema in some of the bronchial type cases and the patchiness of the edema. The thighs sometimes showed marked swelling when the legs were normal. The genitals seldom showed edema. Ascites were present in thirty-eight cases, doubtful in six, not detected in twenty-four. Hydrothorax was thought to be present in forty-five cases, doubtful in five, and absent in eighteen. In a few doubtful cases an exploratory paracentesis was done, and each time fluid was found. The spleen was palpable in thirty-three cases, thought to be enlarged as shown by percussion in six, and apparently not enlarged in thirty. Enlargement of liver and spleen occurred in a much lower percentage of cases early in 1916 than of those admitted at a later date. The liver was felt below the costal margin in thirty-six patients and not felt in thirty-two. Albumin was found in the urine of all patients examined, but the percentage of albumin was not always proportionate to the severity of the case.

The temperature was always normal during stay in hospital in nineteen cases, and above normal in forty-seven. In most of the nineteen cases of normal temperature the patient was not admitted until over a week after the onset of symptoms, and it is probable that they had fever before admission. None of the cases of bronchitis went on to a broncho-pneumonia.

During the acute stage of all cases the blood-pressure,

diastolic and systolic, was taken once a day and sometimes morning and evening. The systolic blood-pressure was 135 mm. Hg. or over in all but two cases examined. In one of these the diastolic pressure was raised, but the systolic was normal. In the other both were normal. In the most severe cases the pressure was always very high, 180 to 210 systolic, the diastolic 100 to 120 mm. An aneroid sphygmomanometer was used. There was no apparent relationship between the blood-pressure and the amount of albumin in the urine, but an interesting fact was that in the more severe cases the amount of subcutaneous edema was usually inversely proportionate to the height of the blood-pressure. In the patients with marked edema the systolic blood-pressure averaged 10 mm. lower than in those with moderate edema. The rise of blood pressure in the evening over that of the morning, reported by Abercrombie (3), was not present in my experience.

In seven cases the pressure of the cerebro-spinal fluid was tested to see if headache was due to increased pressure. In four cases it was not increased, being between 120 and 130 mm. water. In three of these the headache was severe, and two of them received no relief from withdrawal of fluid. The third had had a slight convulsion and fell asleep after the puncture was done.

In three cases the pressure of the spinal fluid was found to be increased. In two of these cases the headache was severe, and in one the headache was not eased by withdrawal of fluid until the pressure was normal. The other patient was unconscious following a severe convulsion. The third patient had no headache, although his pressure was 230 mm. of water. There is apparently no connection between the headache of this disease and the pressure of the spinal fluid.

It was also found that the pressure of the blood and of the spinal fluid bear no relationship to each other, for removal of spinal fluid had no effect on the blood-pressure unless the pressure of the spinal fluid was reduced to a dangerous degree, when a fall in blood-pressure occurred.

The percentage of urea in the spinal fluid is probably of considerable importance, but to date I have tested so few

cases that I cannot give an opinion of my own. French workers have reported much increase in the urea in the spinal fluid in the uremic type of case.

Treatment.—With rest in bed and a simple diet of milk and milk puddings the large majority of cases improve rapidly. As we had to send our patients on as soon as they were fit to travel, I cannot speak of late results. The symptoms calling for active treatment are cough, dyspnea, decrease in urine, headache, and convulsions.

If a patient was markedly edematous or his blood-pressure high a hot-air bath was given. In nearly all cases this produced free sweating, relieved the cough and headache, and decreased the edema. The patient's bowels were kept fairly free with Epsom salts, but patients were not severely purged. If the dyspnea did not then subside and was severe, oxygen inhalations almost invariably gave considerable relief.

After losing two patients whose deaths were both directly due to the affection of the lungs and pleurae, oxygen treatment was given to all cases of extreme dyspnea, and apparently carried several severe cases through, but when the dyspnea was not relieved by oxygen, and later, when the use of oxygen was forbidden owing to shortage of oxygen supply, aspiration of the hydrothorax was carried out, and immediate improvement resulted. One patient who was *in extremis* and appeared likely to die within five minutes was aspirated. After the removal of the fluid he was immediately improved and ultimately recovered. The hydrothorax did not recur.

Opium in any form for the relief of cough or sleeplessness I abandoned after some unhappy results from its use. It appeared to increase the patient's cyanosis. For convulsions spinal puncture and withdrawal of fluid was done in three out of four cases. The three recovered and the unpunctured patient died. Why withdrawal of fluid helps convulsions I cannot explain. It is not due, I believe, to decrease of the spinal pressure, but probably to the removal of certain poisons in the fluid. French observers report excess of urea in the spinal fluid. The good results obtained by this method

in delirium tremens, eclampsia, and other convulsive conditions coincide with the results in the treatment of uremic convulsions, and I believe it should be done either when an attack of convulsions is threatening, or as soon after the first convulsion as possible. Morphia gr. ¼ was always given at the onset of a convulsion.

Prognosis.—The mortality in the disease is everywhere reported as low. Three of our patients died. To judge of the seriousness of the disease in cases apparently cured we shall have to wait many years. Only then will we be able to judge if there is a tendency to pass into a chronic nephritis as in the acute nephritis of general practice.

References.

(1) Dunn. *Lancet,* November 18, 1916. Report of Meeting of Royal Society of Medicine.

(2) McLeod, J. W., and Ameuille, P. *Lancet,* September 9, 1916, "Trench Warfare and Renal Secretion."

(3) Abercrombie, R. G. *Journal of the Royal Army Medical Corps,* August, 1916, "Observations on the Acute Phase of 500 Cases of War Nephritis."

THE VENEREAL DISEASE PROBLEM

Justice Hodgins has presented his second interim report on the results of his inquiry into the venereal disease problem. Since his first interim report an Act has been passed, as recommended, making some important provisions on the subject. In that report it was stated that while such a law was necessary as the foundation for complete action, it should be supplemented in order to secure its successful operation. Justice Hodgins now submits the conclusion to which he has come, as to the steps which it is needful to take in order to reach that end. They are:

"That there should be appointed by the Lieutenant-Governor-in-Council a committee to be known as the Ontario Social Hygiene Committee (or some other similar name).

"That this general committee should be large enough and representative enough to permit it being divided into sections devoted to special departments of propaganda.

"The duty of this committee should be, in the first place, to initiate a province-wide movement for the suppression and cure of venereal disease and for the education of the public, young and old, in regard to it; and, in the second place, to undertake such other work in the future as the social conditions of the province seem to demand, if requested to do so by the Lieutenant-Governor-in-Council.

"That from the committees so appointed there should be nominated by the Lieutenant-Governor-in-Council an executive committee, whose chairman should be the chairman of the Provincial Board of Health, and whose duty it should be to supervise and direct the activities of the general committee and to frame regulations for its guidance and to define its powers.

"That there should be also named by the executive committee various sub-committees from among the members of the general committee to take charge of special departments of the work under the direction of the executive committee. Such departments might be: (a) literature; (b) lectures, speakers and films; (c) propaganda; (d) work among employes of industrial plants; (e) education of the young; (f) education of medical students; (g) protection of girls; (h) law enforcements.

"That the Lieutenant-Governor-in-Council should grant, upon the recommendation of the executive committee, such money as, in the judgment of the executive council, might be necessary for (a) literature, (b) travelling expenses of the secretary, lecturers and speakers, (c) the salary of an all-time secretary, (d) such other sums as may be necessary to meet unforeseen or necessary expenditure, which cannot well be borne by private subscription, including the travelling expenses of members of the executive committee only.

"That the executive committee should be charged with the duty of finally approving of the literature, posters and so forth, which shall be issued or published, and none should be circulated without such approval. The executive committee should also be the clearing house for co-ordinating the activities of all

sub-committees, so as to prevent overlapping, and also to stimulate and promote effort along the most approved lines.

"I further recommend that the Dominion Government should be approached, and if possible, in connection with other provinces who are stirring in this matter, and asked to take steps to (1) form a Federal Department of Health; (2) to extend and enlarge the present military hospital for venereal disease, so as to admit civil patients, and to permit instruction to students and others to be given therein; (3) to erect detention houses for those infected with venereal disease, and who are either dangerous to public health or incorrigible; (4) to make a grant to each of the provinces interested equal to the amount provided by a province in carrying on its campaign against venereal disease, including therein the cost of clinics; (5) to provide a sufficient supply of salvarsan, or its equivalent, free of cost, and permit its manufacture under proper supervision by either provincial agencies or private individuals or companies; (6) to appoint an official with military rank, with the approval of the Lieutenant-Governor-in-Council, who should be an official of the Provincial Board of Health, to take charge as secretary of the propaganda under the direction of the executive committee, and to pay one-half of his salary. He to act also as licence officer with the military authorities in connection with their hospitals for venereal disease.

"That a survey should be made of the provisions of the Criminal Code and the Statute Law of the province in order to see whether amendment or addition is required to be made thereto, so as to permit the full benefit of the campaign against venereal disease to be reaped and to lay before the Legislature and the Minister of Justice results of such survey so that necessary legislation may be passed without delay. That special attention should be paid to the matters referred to in this report, namely, the offence of soliciting, the care of young and working girls, and the advisability of enacting an abatement and injunction law, and one requiring certificates of health before the issue of marriage licenses and the inspection and regulating of rooming houses.

"That the establishment of a proper and compulsory course

in the medical faculties of the universities in venereal disease for medical students, and a post-graduate course for medical practitioners, should be required, and also that this subject should be included in the instruction at the nurses' training schools.

"That the Crown Attorney and all officials concerned with the administration of the law should be reminded of the necessity of having laws touching sexual immorality and venereal disease rigidly adhered to and properly administered, and that an effort should be made to bring uniformity of decision.

"That juvenile courts should be set up in all the large cities and in the chief border towns.

"That clinics, pay and free, should be established in all important municipal centres under such regulations as may be laid down by the Lieutenant-Governor-in-Council, and that a definite grant should be given to all municipalities setting up these clinics in order to secure their continuance. This grant to be proportionate to the amount voted or contributed in the municipality.

"That such of the above recommendations as properly fall within the purview of the general committee should be taken up by it and the results of the deliberations should be formulated by Governmental action, wherever that is needed to make their conclusions effective."

"Ontario is the first province to enact a law which can be made the background for practical work in stamping out or lessening the ravages of disease," he says, "and I desire in this second interim report to outline and recommend the steps which I think can and should now be taken to enable the province to complete its work so far as Governmental action is expedient in this direction."

Referring to immigration Justice Hodgins says: "It ought not to be difficult in the present state of public opinion in Great Britain to arrange for proper inspection at the port of departure. In regard to allied countries, the matter may not be so easily arranged, but if a sufficiently firm attitude is maintained by the quarantine officers, backed up by appropriate legislation, it will be so much in the interests of the steamship companies

themselves to carry none but approved emigrants that action may be expected, wherever they embark, to prevent those who could not pass inspection in Canada from sailing from any civilized port."

"Salvarsan," a medical necessity, under various names, in dealing with venereal disease, is protected by a German patent. In Canada only two licenses to manufacture it have been granted, and five per cent. of the gross sales has been reserved, presumably for the ultimate benefit of the German owners. Only one licensee, the Synthetic Drug Company, has made any progress in producing it, although the licenses were granted in 1915, and the Patent Commissioner has refused to allow the Provincial Board of Health in Ontario to manufacture it. The reason for this refusal are stated in the judgment of the Deputy Commissioner of Patents, dated 12th July, 1917, as follows:

"In view of the public service rendered by the Synthetic Drug Company the curtailment of their market by the granting of an additional license at the present time would be an injustice to them and the public interest would not be served thereby. It was apparent at the hearing that the present application for a license was for the purpose of enabling the applicant to control the prices charged rather than for the purpose of enabling him to manufacture the product.

"The result of so dealing with this indispensable drug has been that this essential remedy for a national evil can only be obtained on the terms of a royalty reserved as above stated, and at a price fixed by one firm who have a practical monopoly in manufacturing it.

"This consideration for the patentees is no doubt a matter of state policy, but the refusal of a further license, in view of the present great demand for Salvarsan, is a national mistake, unless the Federal Government is prepared to undertake its production on a large scale."

Society Proceedings

THE CANADIAN MEDICAL ASSOCIATION

The Care of Military Mental Cases.

A paper with this title was presented by Major E. H. Young, in charge of the Hospital for Insane Soldiers at Cobourg, Ontario. As a report of definite work done of a practical nature, no paper read at the Conference exceeded this one in value.

Dr. Young said that the war was of special importance from a psychiatric standpoint; but not in the production of novel symptoms or syndromes. In the army these are the same as seen in civilian institutions. We have been accumulating an overwhelming mass of clinical material, under peculiarly favorable circumstances for observation; the effect of which will be to stimulate interest in psychical disorders. A military psychiatrist has many advantages. In civil life a psychopath can live in harmony with his environment if accustomed to it, and remains in it until after his psychosis has made considerable advance. Some go through life without seeing a psychiatrist or an asylum for insane, although they may be suffering from dementia precox or other form of insanity. Then, when slight symptoms of illness occur, the relatives and family physician feel that there is some stigma, they meet the condition fairly in the face. They put off the inevitable as far as possible. In the Army it is the opposite of this. There is an unusual demand placed upon the adaptability of the soldiers; so any unsuspecting weaknesses are soon brought to light in that new environment. Officers and non-commissioned officers quickly notice these weaknesses and have a peculiar method of dealing with them, in a way that does not apply to any other organization. The officers try to correct these weaknesses by

turning the limelight upon them. If anyone has taken training at Shorncliffe who has any peculiarity or weakness, he will be able to appreciate what I say in this regard. You will still remember what the sergeant-major said about the stomach, etc. That method is quite correct and works well with regard to the normal individual. But the psychopath cannot stand it at all. It drives him to avoid the company of other people and brings him into constant conflict with military law; and the unit medical officer realizes the dangers of a psychical infection to men in his unit spreading to other cases. He regards the man as insane and makes an effort to get quickly rid of him. He gets him under observation as soon as possible. When the presence of a psychosis is recognized in civilian life, there is a good deal of medico-legal form to be gone through with, stigmatizing to the individual. In the army the procedure for admission to the hospital is as easy for mental cases as for one with a pulmonary or cardiac lesion. No difference. This military system operates to get the patient under treatment when treatment is most likely to be effective.

The Cobourg Military Hospital for psychopathic cases for the C.A.M.C. is the only one of the sort in Canada.

It has 425 beds. It receives most of its cases from other military hospitals. Overseas the cases are taken over by the medical officers and skilled N.C.O.'s detailed from the hospital. We take charge of the cases right at embarkation.

They are assigned to a suitable ward. All documents are completed in the train before the patient arrives. Admission is completed expeditiously and without formality. All patients are put to bed and remain there until seen by the doctor, who prescribes treatment. No patient exhibiting manifestation of insanity at all conspicuously is allowed to go about. The symptoms soon abate. This is good for the patient himself and for the other patients.

The therapeutic facilities it is not necessary to describe—pretty much the same as in other military hospitals. There are no bars, no padded rooms; no sound-proof rooms, no straight jackets. We have the full equipment for ordinary medical, surgical and special-sense services, as well as laboratory facilities. We have also the necessary dentists and facilities for

hydrotherapeutic, electrical treatment, X-ray work and medical gymnastics. We are able to make it resemble a general hospital; that organization is kept in view. We have seven medical officers on the staff to give daily medical attention to each patient. All wards are in charge of nursing sisters, day and night. There is an absence of violence and unseemly conduct. It surprises the new patient to find that he is being cared for by a woman. When you consider that the average medical officer in a hospital for the insane has anywhere from 400 to 600 patients to attend to, you can imagine the difference where there are seven medical officers to a population of 236 patients (at the present time). Occupation courses are given under the care of the employees of the Soldiers' Civil Re-establishment Department. There are three grades: Bedside, ward work and employment in the workshops. Efforts are being made to have the patients progress from the lower to the higher grades. The same personnel furnishes the amusement. This work is of great value in keeping the patients from becoming melancholy. It is therapeutic in its nature. The amount is prescribed by the medical officer and the effects are recorded.

Instead of having to consider the effect of the industries on the cost of maintenance, as is done in ordinary hospitals for the insane, no difference is made in respect to those military cases. They are accorded the same privileges as other classes in regard to special consultants, *e.g.*, to cope with dental conditions, two officers from the Canadian Army Dental Corps. Most of them are in attendance, and are kept busy. Asylums have no dentists on their staff, though some of them have 1,200 patients. There is no doubt about the importance of mouth infections. Infections of every kind enter into the causation of the psychoses. The advanced case of dementia precox is supplied with an artificial limb, just as the limbless soldier is, who has no psychosis. The effects of this treatment are reflected in the results obtained.

The general public takes a great interest in our work. These patients share with the other soldiers the interest of the public. Members of the Red Cross societies and of the Soldiers' Civil Re-establishment and other local organizations have

contributed generously of their time and means for the welfare and contentment of the patients. Free mingling with the public is encouraged; it prevents institutionalism; it dispels all feeling of separation from the outside world. Those in charge of many civil institutions complain that they cannot adopt this policy owing to the comparative inaccessibility of the hospitals and the apathy of the general public.

No patient is discharged until the opinion of the medical staff is secured—the standing medical board. Is he fit to go back to civil life, or under the care of the Soldiers' Civil Re-establishment, or shall he be admitted to a hospital for insane? It is through the co-operation of the S.C.R. that the C.A.M.C. have still supervision from the time they leave the borderland throughout the entire course of their disease. Eight hundred cases have appeared before the board; 400 have been sent back to civil life. No serious accident has marred our history under non-restraint. We have carried out further than ever before the care of these patients as though in a general hospital with a general hospital organization. Twelve hundred cases have been admitted and cared for: no suicide, no homicide or other serious happening. Our work has been carried on with no inconvenience to our neighbors. In Canada we have to-day an acute psychiatric problem. In the larger general hospitals there should be a psychiatric department. A more intimate association with the other branches of medicine is necessary for the elucidation of its problems. If the C.A.M.C. can satisfactorily take care of mental cases, there is no reason to suppose that there is any insurmountable object in carrying on such a work in connection with any large general hospital. Only in this way can the civilian insane obtain the same advantages in regard to humane and rational treatment as the military cases receive.

After thirteen years in this work, I must say there is nowhere I've ever worked where there were as good facilities for treating these classes of cases as has been provided by the C.A.M.C. for these insane soldiers.

THE CANADIAN MEDICAL ASSOCIATION

At the recent meeting of the Canadian Medical Association, held in Quebec on June 25-28th last, the following resolution was moved by Colonel Herbert A. Bruce, of Toronto, and seconded by Colonel Geo. E. Armstrong, Montreal, and unanimously adopted.

That the Canadian Medical Association takes this opportunity, the first after the cessation of hostilities, to record its deep appreciation of the sacrifice made by our profession in Canada during the long war which has just ceased. We are proud to think that no class in Canada has done more to show its patriotic and sound citizenship than the medical men. It is with deep feeling we offer our sympathy to the relatives of those medical men who have so nobly given up their lives for their country, and to those who have sustained wounds and loss or deterioration of health as the result of war service. We feel that the medical officers, nursing sisters and the rank and file of the Canadian Army Medical Service by their patriotic and self-sacrificing devotion to duty have contributed in a large measure to the winning of the war, and have reflected great credit on Canada. It is evident that even though the war is now over, a permanent army medical organization must be maintained and the following suggestions are offered in order that we may profit by the experiences gained in this war:

1. That a course be given in each Canadian medical college on such subjects as medical history of the war, military sanitation, military medical organization, etc.

2. That a research fellowship be established by the Militia Department in each medical college in Canada, for graduates who show special aptitude for such work, and that provision be made for their accommodation in the National Health Laboratory, which, we understand, is to be established in the Federal Department of Public Health.

3. That the rate of pay of the medical officers of the permanent medical army service be put on a par with the R.A.M.C., in order to attract the better class of medical men to the Canadian Medical Service.

4. That these and other suggestions for the improvement

of the Canadian Army Medical Service be referred to a committee constituted as follows: President of the Canadian and of the Provincial medical associations, one member nominated by the faculty of each medical college in Canada and the following officers:

Brigadier-General A. E. Ross. C.B.. C.M.G., C.A.M.C., Kingston.

Col. C. Peters. D.S.O., Montreal.

Col. J. D. Courtney. Ottawa.

Lieut.-Col. F. H. Mewburn. O.B.E.. Calgary.

Lieut.-Col. F. McTavish. Vancouver.

Lieut.-Col. S. W. Prowse, Winnipeg.

Lieut.-Col. Charles Hunter. Winnipeg.

Lieut.-Col. Clarence Starr. Toronto.

Lieut.-Col. J. Hayes. D.S.O., Halifax.

Lieut.-Col. Munroe. Saskatoon.

Major Harry Morrell. Quebec.

And the Mover and Seconder of the Resolution. and that this Committee be given power to add to its numbers.

That a copy of this resolution and report of tthe Committee be forwarded to the Prime Minister of Canada.

It will be interesting to note that an attempt was made by the Executive to prevent this resolution and two others coming before the General Session of the Association on the ground. that a criticism of the C.A.M.C. might be considered as reflecting upon the Government.

In order to shelve these resolutions the Executive reported to the General Session that in their opinion no resolution of a political character should be passed by the Association.

The action of the Executive was vigorously combatted by Colonel Bruce. who pointed out that there was nothing in the constitution giving the Executive the power to decide whether a resolution should be brought before the Association or not.

Is this important Association to be prevented from discussing a subject because it may be considered to have a political bearing, thus nullifying its influence upon matters which may be of the greatest importance to the health of the people. Surely one of the most important duties of this National Association of medical men is to place its professional knowledge

at the service of the State and try to influence legislation in the direction of improving the health and welfare of the community at large, quite regardless of the effect upon the fortunes of any political party.

Colonel Marlow supported the position taken by Colonel Bruce.

The Executive Committee had amongst its numbers a member of the Federal House and succeeded in shelving the resolutions of Colonel F. W. Marlow and Major F. N. G. Starr.

ACADEMY OF MEDICINE, TORONTO

The Toronto Academy, at the stated meeting, on March 4th, listened to a paper of Dr. Alan Brown on A New Protein Milk Powder. This powder is the result of five years of the experimental work of Dr. Brown and several collaborators at the Hospital for Sick Children, Toronto—carried on in the laboratory and in the wards. He presented the subject so that it would be better known among general practitioners in order that they may use it with great advantage. The powder is not on the market yet, but will be put on shortly. This milk has been prepared in powder form because it can be transported more easily than the liquid form, and it will keep several months. Much has been written respecting protein milk, but in spite of its widespread employment, it was almost unknown to the general practitioner. For years practitioners had tried to make out what the difference was between the tolerance for cow's milk and that of the mother's. Over-administration of any one element may cause trouble. The amount of protein in the cow's milk is higher than in the mother's. In human milk there is more whey protein than casein; in cows there is more casein than whey. So cow's milk is much harder to digest, because the casein protein is coagulated in the stomach into tough curds. The whey protein is not. The cow's milk contains a somewhat higher percentage of salts.

Within the last few years, however, individuals working on infant feeding have focussed on various injuries to the child, due to sugar. It is the concensus of opinion now that sugar is the element which causes the greatest disturbances. If we could

change the sugar content we would overcome a serious objection to the employment of cow's milk.

Finklestein, who initiated protein milk, fed a series of infants on cow's milk casein and mother's milk whey, and found the children thrive as if taking mother's milk, showing that the casein does not have any injurious effect, no matter how high a percentage of it may be used. In other cases he fed cow's milk whey with mother's milk casein and had trouble. So most of the trouble was in the whey. There was a secondary pathological fermentation of carbo-hydrates and of the fats.

Now we determine the character of the bacteria by the food given. The frequent acid-green explosive stools are caused by carbo-hydrate concentration with fermentative bacteria, acting on the carbo-hydrates and the fats. These saccharlytic bacteria produce fatty acids, which increase peristalsis and the flow of mucous, wastes the sodium and potassium salts, with consequent demineralization and acidosis, which adds to the toxemia.

Mother's milk contains, approximately, 4% fat, 7% sugar, and 1% protein. Cow's milk—4% fat, 4.5% sugar, and 3.5% protein.

We feel protein is the greatest weapon we have in dealing with artificial disturbances, and that if we can add a large quantity of casein to the food we will overcome many difficulties.

Colic in young infants is due to an excess in the percentage of sugar. If we add protein we can overcome the trouble. The intestinal content of the breast-fed infants is acid; that of the bottle-fed is alkaline.

A large quantity of protein makes putrefactive material and an alkaline stool; the large quantity of sugar in the mother's milk encourages the growth of organisms.

A child fed on a poorly-balanced, high carbo-hydrate mixture, as present in many patent foods, may lose one-third of its weight in two or three days. Another child may lose slightly or not at all, depending on water-binding power.

This water-binding power has a great deal to do with the prognosis and treatment. When these patent foods with a large quantity of carbo-hydrate, small amounts of protein and fat, are used there is stored up in the system a large quantity of water loosely bound—"water babies," the infants are termed,

owing to the fact that when they are afflicted with diarrhea they lose their tissue—it passes out by the bowel in the stool. That type of child is characterized as having a poor water combining power, in contrast with the child on a balanced ration.

In giving protein milk, a sugar not easily fermentable should be used, dextro-maltose being preferred. Instead of pathological fermentation, we get putrefaction, which changes the acidity of the intestinal into an alkaline condition. The potassium and sodium and water loss is stopped. The calcium and magnesium retention is lowered. This does not mean that vegetaril balance is increased by salt ingestion.

The formula of the fluid composition protein milk first tried is fat, 1.5; sugar, 1.5; protein, 3.5. This produces an alkalinity of the intestinal contents—in which putrefactive organisms thrive. This is useful in diarrohoea. All diarroheas are due to fermentation, except the infections. This large amount of protein changes an acid medium into a putrefactive, and we get a stool characteristic of this type of milk.

The speaker then described the many difficulties in preparing this type of milk. The powdered form contains considerably more of the sugar than that in the liquid preparation. The powder is rather unpleasant to the taste, but infants do not seem to mind that. The caloric value is only about one-half that of an equal quantity of cow's milk. But the administration of this powder tends to correct the bad condition. If the child is on the breast it is usually administered before each feeding.

Histories of cases were then read and charts exhibited showing the good results which had followed the administration of this new protein milk powder in the various forms of intestinal indigestion—colic, the ordinary summer complaint, and even in infectious diarrheas.

Dr. Brown was warmly complimented for his contribution to the problem of Infant Feeding.

Officers for 1919-1920.

President—E. E. King.
Vice-President—J. H. Elliott.
Hon. Secretary—F. C. Harrison.
Hon. Treasurer—J. H. McConnell.

Members of Council—B. P. Watson, H. B. Anderson, H. J. Hamilton, R. T. Noble, Alan Brown, D. J. G. Wishart, W. A. Carswell.

Chairman—Section of Medicine— G. S. Young.
Chairman—Section of Surgery—B. Z. Milner.
Chairman—Section of Pathology—I. A. Oille.
Chairman—Section of Ophthalmology—Mortimer Lyon.
Chairman—Section of Pediatrics—A. H. Spohn.
Chairman—Section of Obstetrics—K. C. McIlwraith.
Chairman—Section of State Medicine—M. B. Whyte.

THE CANADIAN ASSOCIATION FOR THE PREVENTION OF TUBERCULOSIS

Differential Diagnosis was the title of a paper by J. S. Pritchard, M.D., Battle Creek, Michigan. When is a tuberculosis case active? the essayist inquired. Danger of errors in diagnosis are often made by arriving at too hasty conclusion on limited evidence, such as indefinite physical findings. Moisture may persist in the chest for months in non-tuberculous pathology. Localized rales are not always caused by a tuberculous lesion. Clinical symptoms must be carefully investigated. It is necessary to acquire an adequate knowledge of internal medicine in order to become proficient in any specialty.

Of very great interest was the paper of Dr. C. D. Parfitt, Gravenhurst, on "Artificial Pneumothorax." The results during a period of five years were analyzed, and a series of efficient compressions were contrasted with a series of cases in which the procedure proved impossible, by way of showing the relative value of this method of treatment. Incidents and complications met with were described, and a series of instructive case records were given. Dr. Parfitt concluded by telling the indications for this particular treatment.

In the course of an excellent paper on "Tuberculin Treatment," Dr. J. H. Elliott, Toronto, gave a résumé of cases, most of which were non-pulmonary. He stated that splendid results had followed the treatment in many instances, particularly in glandular tuberculosis, tuberculides, tuberculous sinuses after spontaneous evacuation of abscesses, or following operation for the relief of various tuberculous conditions.

J. A. Machado, President of the Association and a prom-

inent worker along these lines, read an excellent address. He advocated the federation of all the agencies co-operating in this great work. The vital importance of educating school children in all matters of health was urged, that they might become strong and sturdy citizens, and fit for their part in the world's work. The speaker paid a high tribute to the work being done by the Invalided Soldiers' Commission, which had opened the eyes of thinking people to the splendid accomplishments possible in the treatment of tuberculosis.

Dr. J. H. Pryor, of Buffalo, described the Rollier method of treating tuberculosis by means of sunlight, ultra-violet rays, fixation, position, etc. The method was, he said, adapted to all forms of surgical tuberculosis cases—bones, joints, glands, or peritoneum. All the sunlight available was utilized, and on cloudy days the artificial light was used. An hour a day of sunlight was utilized, if no more could be secured. The ultra-violet ray was not equal in value to the sunlight. Protection from the wind was important. The tubercular lesion itself is not exposed until the patient's skin was a chocolate-brown all over. Otherwise, results were harmful.

The first day the patient is exposed 10 minutes, the feet only; the second day, the feet 20 minutes, and thighs 10 minutes, increasing the length of exposure and the amount of body surface daily. In three weeks the whole body may be exposed. Care must be taken lest the patient be burned. They had had such mishaps at Buffalo. For sunburn, Dr. Pryor used spirits of camphor. As a rule, when the patients became chocolate brown in color improvement took place. Glands were never operated upon by them, and they opened abscesses only on rare occasions. Joints loosen up in a wonderful fashion—there was no ankylosis in the majority of cases. All gland cases recovered, without exception; in 30 cases of tuberculosis of the peritoneum, 29 recovered! In all bone cases, motion was restored and the results were generally favorable.

The following officers were elected for the Canadian Association for the Prevention of Tuberculosis, as follows: J. A. Machado, Ottawa, President; Sir Geo. Brown, Ottawa, Hon. Treasurer; Dr. George D. Porter, Secretary. The following were added to the list of vice-presidents: J. E. Evel, Lieut.-Col. McKelvey Bell, Mrs. P. D. Crerar, E. L. A. Chubbett (Brantford), Dr. Byert (St. Agathe), and Dr. A. R. Miller (Nova Scotia), were added to the Executive Committee.

Personals

Dr. R. W. Mann, 184 Bloor Street E., Toronto, has decided to devote himself to internal medicine and laboratory methods.

Dr. Herbert E. Clutterbuck, F.R.C.S.Ed., 148 Grace Street, has returned to Toronto and will in future confine his practice to general surgery.

Dr. D. King Smith, 22 Wellesley Street, Toronto, has resumed practice, and will confine his work, as formerly, to diseases of the skin.

Dr. F. S. Minns, 14 Bloor St. East, Toronto, wishes to intimate that he is now devoting special attention to diseases of the upper and lower respiratory tract.

Dr. Oliver Mabee, 419 Bloor Street West, has returned from overseas and will confine his practice to general surgery as before.

Dr. George Strathy has returned from overseas and has resumed practice at 143 College Street, Toronto. He will confine his practice to internal medicine.

Three Toronto nurses—Miss M. C. Stewart, Miss Kathleen Ponton and Miss Alice G. Turner—have just been awarded the Royal Red Cross, second class. Miss Stewart is a graduate of the Toronto General Hospital, Miss Ponton of the Hospital for Sick Children, and Miss Turner of St. Michael's.

The Distinguished Service Order has been awarded to Major Charles Fraser Knight, M.B., 1913, whose home is in Moose Jaw, Sask. He joined the R.A.M.C. with the rank of lieutenant and after serving in Saloniki and in the East with General Maude as a regimental surgeon, became attached to the 133rd Field Ambulance.

Capt. Dr. Arthur Vincent Leonard has been officially reported as having been drowned when the hospital ship *Llandovery Castle* was sunk on June 27th, 1917, by a German submarine. His mother, Mrs. A. Leonard, resides at 1470 King St. West, Toronto. He had been attached to the 2nd Canadian Field Ambulance in France for two years, and was a doctor on board the *Llandovery Castle* for nine months.

Dr. Alfred Massey, son of Mrs. Massey, formerly of Belleville, has won distinction in the Belgian Congo, where in appreciation of his services as Medical Officer over a battalion of native troops, he has been awarded the rank of Major and decorated with the Croix de Chevalier de Corde Royal de Lion. Dr. Massey went to Africa about twenty years ago as a medical missionary.

Col L. E. W. Irving, D.S.O., who has been Assistant Director of Medical Services in this military district, is retiring to private life, and will be succeeded by Col. F. S. L. Ford.

Col. Ford, who comes from Halifax, went overseas as a medical officer with the First Canadian Division. After considerable service at the front he was for a time Assistant Director of Medical Services under the Clearing Depot Services command.

The Ontario Legislature, at one of its sessions the last week of March, placed in the estimates the sum of ten thousand dollars for medical and dental inspection in the public and separate schools. Hon. G. Howard Ferguson explained that this sum was intended to be used chiefly in propaganda work. The Department intends to encourage, particularly rural school boards, to introduce inspection in the schools, and the propaganda work will be partially carried out through the Women's Institutes.

After three years' absence on military service, Dr. A. Grant Fleming, analyst in the laboratories of the local Health Department, has returned to his duties. Dr. Fleming was medical officer to the 4th Battalion in France during the German offensive of March, 1918, and the later advance of our armies to Mons. He left the front a week after the signing of the armis-

tice. Dr. Fleming was recalled from England by Dr. Hastings to take charge of the city's laboratories, in place of Dr. Adams, who was recently appointed Health Officer for the border district at Windsor.

Dr. Harvey Clare, formerly Superintendent of the Toronto Reception Hospital, Assistant Superintendent of the Queen Street Hospital for the Insane, has been appointed Medical Director of the Ontario Hospitals. The office is a new one and is taken as a forward step in institutional management. Dr. Clare is to have general supervision of the medical work in connection with the Ontario Hospitals and will furnish the Minister with reports of the movement, discharge, transfer, etc., of patients, also reporting on the equipment, accommodation and furnishings of these institutions.

Amongst the medical officers who have recently returned to Toronto, and are already out of uniform, there are Major W. E. Gallie, 143 College Street, who returned early in August after spending sixteen months in England; Lt.-Col. George S. Strathy, who has the proud record of having been in uniform for fifty-two months, and who recently was in charge of medicine at Orpington Military Hospital; Lt.-Col. Graham Chambers, who left Toronto with No. 4 General Hospital in 1915, and who has latterly been in charge of medicine at Moore Barracks; and Lt.-Col. C. A. Warren, who went to Siberia, and was in command of the 16th Field Ambulance, C.E.F.

Dr. E. T. Adams, of Toronto, who served in France with the Sanitary Corps of the Canadian Army for more than two years, has been appointed Medical Officer of Health for Windsor District, a position recently created by special Act of the Legislature. Commended by officials of the Ontario Health Department and of the University of Toronto, Dr. Adams is said to have special qualifications for the position of Medical Officer of Health. His salary, as fixed by the Essex Border Utilities Commission at a special meeting, will be $4,000 for the first year.

The personnel of the new Board of Health will be decided by the Commission shortly. Each of the five municipalities will have one representative on the board.

Publisher's Department

THE BEST CATHARTIC

Upon the authority of the United States Dispensary, "good castor oil is decidedly, as a rule, the best and safest cathartic for children."

From the same source, we learn that "as found in commerce it is often tinged with yellow and has an unpleasant odor and hot acrid taste."

In the first statement we have the reason why the drug has been in use for upwards of three thousand years; in the second, the principal cause of its somewhat restricted professional employment to-day.

The qualifying word "good" furnishes a key to much of the inattention to oleum ricini on the part of the medical profession; if the available product be not good, it is natural that physicians will neglect to use it.

Good castor oil does not long remain good when exposed to atmospheric influences and changes of temperature, consequently the bulk product cannot be expected to be perfect when dispensed.

Immediate and complete evacuation of the intestinal contents is frequently not only advisable but imperative, in order to prevent serious infection by absorption into the blood of toxins developed in the stagnant bowel. No drug so thoroughly and inoffensively effects this purpose as castor oil.

Over-indulgence in alcoholic beverages, "catching cold," enforced idleness due to injury, surgical operation, sudden illness or parturition, will produce temporary constipation, which calls for prompt correction. Oleum Ricini is not surpassed, possibly not equalled, by any other drug for the purpose.

Retention of indigestible or undigested food material in the intestine is productive of colic and diarrhea, particularly in children; a bland, unirritating cathartic is indicated, one that

will act speedily as a cholagogue, hydragogue and peristaltic stimulant; the salines effect only a large watery excretion, which, however, may fail to carry away the offending matter. The enema, as ordinarily administered, empties only the rectum; when high flushing is resorted to, the effect is incomplete.

One full dose of castor oil, on the other hand, acting as it does upon every part of the intestinal tract, empties the canal from end to end.

Oleum Ricini is just as splendidly adapted to the use of adults as it is unequalled for administration to children; it stimulates the mouth of the common bile duct, consequently activates the gland, whose product is discharged through it; it is therefore an effective cholagogue, entirely suited to the treatment of defective hepatic function.

Whatever ill-founded reason for its non-use may obtain in the argument that it is generally undesirable to prescribe or order a drug that the patient is familiar with, is negatived by the unique remedial utility of castor oil.

The physical ground for objection, which lies in its disagreeableness, is absent from the sweetened and flavored Laxol, which is the most notable attainment in the preparation and preservation of oleum ricini.

Laxol is fresh and free from rancidity wherever obtained, because it is sealed airtight as soon as bottled; it is palatable, by reason of the incorporated flavor and sweetening; it is takable, on account of the salivary secretion excited, serving to prevent it from adhering to the buccal membrane.

Laxol needs no preparation, no vehicle or disguise. It may be ordered to be taken just as it comes and no patient will experience difficulty in so doing.

THE DIFFERENCE BETWEEN ARHEOL AND SANDALWOOD OIL

Sandalwood oil is distilled from sandalwood. It is a coarse, ill-defined, complex product, a mixture of numerous compounds (terpenic alcohols, santalenes, santenes, aldehydes, teresantalic acid, etc.).

Arheol, is a definite compound extracted from sandalwood

oil. It is in reality a sesquiterpenic alcohol having the formula $C^{15}H^{26}O$. Arheol in fact is the active principle of sandalwood oil.

The composition of sandalwood oil varies within very wide limits according to the source of the wood from which it is distilled and the process adopted for its extraction. It follows that the oil is of necessity a somewhat uncertain medicament and its therapeutical effects vary accordingly.

The employment of sandalwood oil not unfrequently gives rise to grave disturbances (nephritis, gastritis, colic, etc.). The disturbances become more and more marked the longer the treatment is continued, and the less Arheol the oil contains: the more there is of the constituents other than Arheol the more intense they become.

The administration of Arheol even in large doses on the contrary never occasions any kidney or stomach disturbance however long the treatment is persevered with.

Sandalwood oil (even when not adulterated) contains a very variable proportion of the active principle, from 30 to 90 per cent., so that a much larger dose has to be taken in order to obtain the same effect.

Arheol being the active principle of sandalwood oil is necessarily vastly more active, weight for weight, than the oil. It acts almost immediately, its effects are constant and durable, it being a pure product, and the dose required is always much smaller than would be necessary when other products are prescribed.

Arheol, is a definite, chemically-pure product and is therefore always identical in composition. It presents the immense advantage over all other balsams of being an absolutely uniform product on the therapeutical action of which we are entitled to rely, by reason of its absolute purity.

THE PINE SANITARIUM*

The following report from the Pine Sanitarium, Chicago, Ill., speaks well for the care given them.

Case No. 9727—Age 54 years—Housewife. Has taken morphine hypodermatically 3 to 5 grains daily for a period of 12

years. Cause of addiction—Gall Stones. Has had no other serious illness. Both parents died at 73 years. Father apoplexy. Mother—Cardiac Asthma. Condition of patient on entering: General Condition—fair. On train bound for Chicago, the patient sat near an open window and severe laryngitis resulted. Heart—negative; arteries—sclerosed; liver—pain and tenderness over gall bladder; digestive tract—evidence of gastric ulcer; kidneys—negative; bowels—constipation, enema required before each b. m. Hemorrhoids. Urinalysis—negative. On account of acute attack of gall stones, the treatment was delayed for two weeks. During this period much morphine had to be used. Patient suffered no pain during the active treatment and made a splendid recovery. Her condition when dismissed five (5) weeks from time of entering was very good. Sleeping from five to six hours nightly. Appetite splendid. Has no pain over liver region; bowels regular and hemorrhoids give no trouble whatever. Three months after leaving, patient had an acute attack of gall stone colic. Operation performed and patient made uneventful recovery.

IS ANOTHER "FLU" EPIDEMIC COMING?

Let us hope not. But the *possibility* must be faced and we must be ready for it if it does come. Whether or not an actual epidemic occurs, it is almost certain that there will be many infectious "colds," coryzas, grippes owing to the weakened vitality of many who have recovered from their former attack, and for other reasons.

A remedy which stands right at the very top is Calcidin, Abbott. During the epidemic of last year and since there have been hundreds of reports of its successful use in thousands of cases. One physician reported over 1,800 cases in which the dominant remedy was Calcidin without a single death and very few complicating pneumonias. Other reports are from a dozen cases up to 500 and practically every doctor reports "there was not one died."

For many years Calcidin has been the favorite prescription of thousands of physicians for "coughs, colds, croup." It gained new thousands of admirers during the epidemic. If there is

another attack or even the expected increase in common colds, Calcidin will be in greater demand than ever before. Physicians who have learned that best results follow when Calcidin is used promptly and in dose sufficient, will be ready for whatever comes by stocking up for their own use or ordering their pharmacists to carry plenty of it ready for emergencies.

The Abbott Laboratories, sole manufacturers of Calcidin, are prepared for a greatly increased demand for the several Calcidin combinations, as well as the immensely popular Calcidin Troche. Physicians not familiar with Calcidin can obtain samples and literature by writing to the home office at Chicago.

DOCTOR, TAKE A HINT

When in a quandary as to what to invest your next thousand dollars in, bear in mind that many of your own profession are already satisfied holders of the debentures of the Canada Permanent Mortgage Corporation. You cannot make any mistake in following their example, as such an investment can be put away in your safe and forgotten till the half-yearly interest date comes round. The first consideration of the Directors and Officers of this Corporation has always been the absolute safety of the funds entrusted to their charge. That this policy of extreme carefulness has been appreciated by the public is evidenced by the continued growth of the Corporation, its assets now amounting to over thirty-one million dollars.

The Canada Permanent was established in 1855.

A PHYSICIAN'S EXPERIENCE

The best all-around medicine for continuous and daily use, fool-proof and non-injurious, quick acting and soul-satisfying is a morning glass of Plutowater, together with a glass of plain water at least fifteen minutes before breakfast, taking just enough to produce one daily stool, writes Dr. H. N. Jennett, of Kansas City, Mo.

The absence of griping is a marked characteristic of Pluto Water. This is due to the fact that it acts as an intestinal bath rather than as an irritant of the mucosa, as characteristic

of most cathartics and even calomel. The advantages of this kind of elimination are apparent, especially so when the continued use of laxatives become necessary.

The French Lick Springs Hotel Company at French Lick, Indiana, will be pleased to forward sample bottles at no expense to the medical profession—who are under no obligations whatsoever.

OAKOAL A REAL FUEL

No class will be more interested in the substitute for anthracite coal than the members of the medical profession. It is universally recognized that the supply of anthracite coal is greatly diminished and Government authorities state that it is very improbable that anthracite will ever again be cheaper, but is more likely to increase in price.

This makes the need of a satisfactory substitute, and inasmuch as Oakoal is the result of a conservation scheme, as well as being the means of solving the problem of garbage and wastes disposal under scientific sanitary methods the discovery of Oakoal will work an epoch in conservation and sanitary problems.

In disposing of garbage and in treating it for a binder in the manufacture of Oakoal which, as a fuel product, tests over 12500 B.T. As. per lb., the company first put it through a boiling process, thus destroying germ life and organic matter, after which ground, pulped and dried, it is mixed with anthracite coal dust, and a chemical solution acting as a deodorant, disinfectant and weatherproofer, it runs through a gigantic masticator, thence through presses with a pressure capacity of 46,000 lbs. per square inch, coming out onto metallic corner belts in two-ounce briquettes ready for use.

Oakoal has been tested by the Government Fuel Testing Laboratory, by universities and briquetting experts, as well as by scores of citizens who burned it last season, and its stock is now offered to the medical fraternity after having attained sufficient subscriptions from the public to insure the company's success.

We do not give this attention to Oakoal simply because of the fact that the company's announcement appears in this issue, but we called to investigate the merits of Oakoal for use in connection with the sick room, and having seen the list of shareholders and the burning of the product, have no hesitation in advising our readers to secure the company's literature.

AN IDEAL RESORT FOR CONVALESCENT PATIENTS

Physicians have frequent opportunities of referring those convalescing from illness to a resort where they can quickly recover their old-time vigor and enjoy an almost ideal climate, 2,500 feet above sea level. Such a resort is Virginia Hot Springs, just one night out of New York. The management have spent a huge sum of money on this choice spot in "Old Virginny," and are anxious that the Canadian medical profession should continue to refer cases there, as they have done in years gone by. The Homestead Hotel is one of the handsomest houses in America. It is built of solid brick, containing 500 guest rooms, with many parlor suites and 300 private baths. It is spacious, dignified, quiet and restful, with magnificent mountain views on every side. It is no exaggeration to say that Hot Springs means the Homestead Hotel. The Company owns 5,000 acres surrounding the hotel, so that physicians can understand that their patients have every opportunity of enjoying outdoor life and regaining thereby their normal strength.

The dominant factor making Hot Springs world-famous is the cure in which the climate as well as the water assist. The waters are conducted by gravity to the bathhouse and distributed fresh from the ground to the bathing apartments on different floors without loss of heat or its increase by artificial means, and fully charged with all their gases and other health-giving qualities. At none of the celebrated places in Europe, and at no other springs in America, is the temperature prescribed for hot baths that at which the water actually emerges from the earth in the natural springs.

The springs are beneficial, not only for bathing, but for drinking. Besides the hot springs, the effects of which as drinking waters are pronounced, there are magnesia, sulphur, and soda springs within the grounds, and alum water from a spring not far distant. The water from the soda spring comes strong and clear from the ground at a uniform temperature of 74 degrees. Physicians should address for full information Christian S. Andersen, Esq.

The Canadian Journal of Medicine and Surgery

A Journal published monthly in the interests of Medicine and Surgery

Vol. XLVI. TORONTO, OCTOBER, 1919 No. 4

Editorials

MENTAL DISEASES

CERTAIN facts respecting insanity are pretty definitely established. Their iteration, reiteration, collation and plain emphatic presentment ought to produce results.

Half our insane are insane as a result of alcohol and syphilis. Banish these two factors and half our insanity disappears. The rapid inauguration of prohibition on this continent will soon cut alcohol out as a cause of mental disease. The discovery of the treponema pallidum, the Wassermann reaction and 606 will help to stamp syphilis out. To complete its eradication we must trust to the influence of instruction in sex hygiene and the inculcation of good morals.

Other types of insanity result from faulty education, environment and wrongdoing. Children have been forced to study subjects for which they have no

inclination or capacity, gone into occupations for which they were not fitted, and failure has been the result, accompanied often by physical and mental breakdown.

At home children have been crowded into the tenements of large cities and exposed to filth diseases, have been underfed, been obliged to consort with the vicious, and finally end up in an insane asylum or in prison.

The unequal distribution of wealth has been a big factor in producing these unfortunate conditions. The day is coming shortly when things will be evened up—much to the relief of the poor and oppressed. When that day arrives much less insanity will be observable. *Mens sana in sano corpore.*

THE BUSINESS SIDE

The editor of the *Medical Standard* says he is aware that it is not considered quite the thing in polite society to hint that the doctor has to do with any such vulgar thing as marketing. He does not sell his wares: he renders services. He does not ask people to engage his services: he waits until they come to him. In the last analysis, however, he does sell his goods, and the buyer buys them just as he buys the merchant's goods. If the doctor does not find some way of making connection between the demand for his services and the supply which he stands ready to furnish, his assets (his knowledge and equipment) might as well be liabilities. He is bound to exercise

some sort of psychology as between himself and those whom he hopes to serve. The fact that he is debarred from making any direct display adds to the subtlety and difficulty of the problem. He must "make connections."

CHILD WELFARE

THANKS to the stimulating activities of the Wellingtonian dynamo in charge of its health office, Toronto occupies a proud place among American (North) cities. Wonderful progress has been made in the matters of securing pure water and pure milk, by which typhoid is almost *non est*. Old abuses in connection with the Isolation Hospital, exposed by *Jack Canuck*, have been rectified, and even more important is the work done to improve the welfare of the city's children. The inspection of schools has nipped numerous small epidemics of contagious disease in the bud. The pre-natal clinics, in which prospective mothers receive gratis the advice of skilled physicians, has produced a condition of affairs by which many of the poorer women of the city are better prepared for motherhood than their wealthier sisters. After the notification of a birth instructive literature for the guidance of the mother is forwarded, and in a few days a welfare nurse calls at the home and supplements the information received at the clinic with personal advice and supervision.

Mothers are urged to visit the city's child welfare clinics. Since 1913 these visitations have increased

from 4,000 to 10,000 annually. Infant mortality during this period has decreased from 137 per 1,000 births to 91.8 per 1,000. Nurses give lectures to the assembled mothers on feedings and the commoner infantile ailments.

Charles J. C. O. Hastings, in his ten years of endeavor, has already erected for himself a "monument more lasting than brass; more sublime than the royal elevation of pyramids."

CANADIAN ASSOCIATION FOR PREVENTION OF TUBERCULOSIS

The nineteenth annual meeting of the Canadian Association for the Prevention of Tuberculosis, will be held in the Chateau Laurier, Ottawa, on Thursday, October the 9th. 1919. The principal items on the programme are: Secretary's Report, Geo. D. Porter, M.B. The X-ray in the Diagnosis of Pulmonary Tuberculosis, Dr. Harold M. Tovell. The Visiting Nurse, Elizabeth E. Harris. What ought to be taught to-day about the Prevention of Tuberculosis, Dr. W. J. Dobbie. Tuberculosis in Infancy, Dr. Alan Brown. The Problem of the Discharged Soldier, Lieut.-Col. J. H. Elliott. President's Address. José A. Machado, Esq. The Present Needs of the Tuberculosis Campaign. Dr. John B. Hawes, Boston, Mass.

Canadian Journal of Medicine and Surgery

Editors

Surgery:
N. A. Powell, M.D., C.M., Professor of Medical Jurisprudence, Medical Department, University of Toronto; Senior Assistant Surgeon in charge, Shield's Emergency Hospital.

Clinical Surgery:
Alex. Primrose, M.B., C.M., Edinburgh University; Associate Professor of Clinical Surgery, Toronto University; Secretary Medical Faculty, Toronto University; Surgeon Toronto General Hospital; and Herbert A. Bruce, M.D., F.R.C.S., Eng., Surgeon, Toronto General Hospital.

Orthopædic Surgery:
W. E. Gallie, M.D., Associate Surgeon, Hospital for Sick Children, Toronto; Clarence L. Starr, M.B., Associate Professor of Clinical Surgery, University of Toronto; Surgeon-in-Chief of the Hospital for Sick Children, Toronto; Consulting Surgeon to Toronto General Hospital; H. P. H. Galloway, M.D., Orthopedic Surgeon, Winnipeg General Hospital; Lecturer in Orthopedic Surgery, Manitoba Medical College; Member of The American Orthopedic Association.

Militia and Naval Medical Services and Ambulance:
J. T. Fotheringham, M.D.; C.M.G.; Colonel, Army Medical Corps, Associate Professor of Medicine and Clinical Medicine, University of Toronto; Associate Collaborator, Chas. J. Copp, M.D., C.M., Hon. Sec. Provincial Council of Ontario, St. John Ambulance Association.

Medical Jurisprudence and Toxicology:
Arthur Jukes Johnson, M.B., M.R.C.S. Eng., Coroner for the City of Toronto; Surgeon Toronto Railway Co., Toronto; W. A. Young, M.D., L.R.C.P., Lond., Ex-President of the American Medical Editors' Association; Associate Coroner, City of Toronto.

Hospital Administration:
Mrs. Amy A. Armour Smith, R.N., New Rochelle, N.Y., Ex-Superintendent, New Rochelle Hospital, New Rochelle, N.Y.; A. K. Haywood, M.B., Toronto, M.R.C.S., L.R.C.P., London, Medical Superintendent Montreal General Hospital.

Pediatrics:
Allen Baines, M.D., Toronto; Associate Professor Pediatrics, University of Toronto; Physician, Hospital for Sick Children; Helen MacMurchy, M.D., Toronto.

Medicine:
W. J. Wilson, M.D., Toronto, Physician, Toronto Western Hospital; J. H. Elliott, M.D., Associate Medicine and Clinical Medicine, University of Toronto; W. H. Pepler, M.D., Junior Medical Assistant, St. Michael's Hospital; and A. J. Harrington, M. D., M.R.C.S., Eng., Toronto.

Clinical Medicine:
Alexander McPhedran, M.D., Professor of Medicine and Clinical Medicine, Toronto University; Physician, Toronto General Hospital; Lewellys F. Barker, M.D., Professor of Medicine, Johns Hopkins University, Baltimore, Md. H. B. Anderson, M.D., Toronto; Associate Professor of Clinical Medicine, University of Toronto.

Mental and Nervous Diseases:
N. H. Beemer, M.D., Mimico Insane Asylum; Campbell Meyers, M.D., M.R.C.S., L.R.C.P. (London, Eng.), Private Hospital, Deer Park, Toronto.

Gynecology and Obstetrics:
B. A. Watson, M.D., Edin., F.R.C.S., Edin., Professor of Gynecology and Obstetrics, University of Toronto; Gynecologist and Obstetrician, Toronto General Hospital; Geo T. McKeough, M.D., M.R.C.S., Eng., Chatham, Ont.; C. F. Moore, M.D., Toronto; and A. C. Hendrick, M.A., M.B., F.R.C.S. Edin., Demonstrator in Gynecology, University of Toronto; Assistant Gynecologist, Toronto General Hospital.

Pathology:
J. J. MacKenzie, B.A., M.B., Professor of Pathology and Bacteriology, University of Toronto; H. K. Detweiler, M.B., Assistant Pathological Dept., University of Toronto.

Ophthalmology:
J. M. MacCallum, M.D., Toronto, Senior Assistant Eye Department, Toronto General Hospital; Oculist and Aurist Victoria Hospital for Sick Children, Toronto. Walter W. Wright, M.B., Assistant in Ophthalmology, Toronto General Hospital and Hospital for Sick Children.

Nose, Throat and Ear:
Perry G. Goldsmith, M.D., 84 Carlton St., Toronto, Laryngologist and Aurist, Provincial Institution for the Deaf and Dumb; Senior Assistant Ear, Nose and Throat Department, Toronto General Hospital.

Dermatology:
D. King Smith, M.B., Tor., Toronto; Demonstrator in Pathology, Toronto General Hospital

Managing Editor:
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont.

Address all Communications, Correspondence, Books, Matter regarding Advertising, and make all Cheques, Drafts and Post-Office Orders payable to "The Canadian Journal of Medicine and Surgery," 145 College Street, Toronto, Canada.

Doctors will confer a favor by sending news, reports and papers of interest from any section of the country. Individual experience and theories are also solicited. Contributors must kindly remember that all papers, reports, correspondence, etc., *must be* in our hands by the first of the month previous to publication.

Reprints supplied at Net Cost

Original Contributions

VISIT TO DR. ANDRE CROTTI'S CLINIC.

By John M. Macdonald, M.B.C.M., Toronto.

The Operating Room is on the sixth floor of Grant Hospital, Columbus, Ohio.

1. *Light.*—There is a circle of eight electric lights over the operating table, so arranged as to focus on the operation. Each light is enclosed in a box like an automobile light.

2. *Sterilization of Hands, etc.*

(*a*) Scrub hands as usual. Dry on sterile towel.

(*b*) Wash hands well with swabs, using iodine solution. Iodine solution for hands: Iodine, U.S.P. 70 per cent; alcohol, 30 per cent.

(*c*) Iodine now washed off with alcohol on swabs; hands are now white.

(*d*) Sterile gown now donned. (Clean underwear and a sterile gown had previously been put on in the wash-up room.)

The sterile gown is simply put on over the other gown. If in the course of an operation he wished a clean sterile gown, it was simply put on over the old one.

(*e*) Hands sterile and gown on, sterile powder is put on hands and dry sterile gloves put on.

(*f*) Previously, patient had been given a hypodermic. Neck is now prepared by iodine, etc., and where incision is to be, it is outlined with alcohol. (No scratch marks used as guide on neck.)

Kocher screen is used to protect the wound from Anesthetist and patient's breath. The patient is carefully draped with sterile sheets and gauze. (Dr. Crotti drapes patient himself.)

Crotti's Method of Draping a Patient for his Transfrontal Resection of the Thyreoid Gland:

(*a*) A sterile sheet with tapes at one end is draped over the patient's body. The tapes are tied round the neck below the goitre, by the anesthetist. The free end of sheet is thrown over a bar near foot of the operating table.

(*b*) Another sterile sheet with tapes at end is thrown over the Kocher screen, and the tapes are tied around the patient's neck, above the goitre, by the anesthetist.

(*c*) Another sheet with a perforation in the centre is now spread over all in such a manner that the goitre is in view in the opening.

(*d*) Sterile gauze is now disposed at the sides so as to further render the operative field safe.

The operator's gloved hands are now rinsed in the bichloride solution and then in sterile water.

Dr. Crotti has as first assistant a Dr. Ramsey. His second assistant is a Russian, Dr. Greenbloom. (No house surgeons are permitted near the operation.)

A description of Dr. Crotti's Transfrontal Resection of Thyreoid Gland.

1. Crotti uses the low collar incision; also, it is extra short as his new method admits of this. Crotti stands on right hand of patient and cuts away from himself—from the right of the patient to the patient's left side. The incision at this stage includes the skin and platysma. These tissues are dissected up and down, and a special retractor is applied. This special retractor is curved to the shape of the neck and is not in the way during the operation. It keeps the lips of the wound well separated.

2. Dr. Crotti now makes the median incision down to Surgical Capsule; he loosens up the muscles from the gland, taking care not to press unduly on it; and opens the Surgical Capsule with due care.

3. The gland is loosened up where needed (gently, of course). He places a finger on the common carotid to protect

it from injury and passes what he calls a "Cooper" through the Thyreoid Gland (any place in the substance of goitre, not too posteriorly, of course.) This "Cooper" is simply a silk traction thread passed on a blunt ligature carrier: being blunt it does not injure blood vessels, so no appreciable hemorrhage results from its use.

4. Traction is made on the "Cooper" and this tends to bring down the Superior Pole to view. Another "Cooper" is similarly passed and traction again made. This "Cooper" is passed above the first one so when traction is made it pulls the superior pole down farther. By the time another one is applied to gland above last one the superior pole is in full view.

(While traction is going on, gentle loosening up may be carefully done, if needed, before "Coopers" are applied. The Kocher Goitre Forceps is applied to act as convenient handle in the manipulations of gland.)

The superior pole is ligated with silk on the blunt ligature carrier. This silk ligature is left long for the present.

The Kocher Haemostat is now applied to the Superior Pole below the ligature. As much gland as was included in the bite of the forceps is cut below forceps, on opposite side of ligature, but forceps are still left on superior pole. The cut is made with scissors. Another forceps takes a bite of Superior Pole. The tissue thus held by the second forceps is snipped through *below* the forceps as before, etc.

By the time the Superior Pole is cut through, perhaps four forceps may be thus applied below the silk ligature. These forceps thus applied to the Superior Pole are left in place for the present, and the silk ligature is for the time being left long.

(The forceps is always applied to inferior Thyreoid Artery to compress it only; when the operation is over this is released and no ligature applied in ordinary cases.)

Traction on the "Cooper" brings the lower pole into view, when needed.

Kocher uses light wire tractors to aid in gland manipulation. Retracting the muscles, etc., from over part of gland he is working with aids greatly.

5. Crotti now proceeds to the transfrontal resection of

Thyreoid. The gland is held up gently out of the way by means of Kocher's goitre forceps. Each cut made in doing the transfrontal resection was preceded by a haemostat placed on gland just below where cut was to be. That is, the haemostat was applied dorsally to position of future cut. The cut was made by "Mayo" scissors. The forceps were applied only on the dorsal border of cut. No bleeding coming from above, no forceps were applied there. That is, as no bleeding came from portion being removed, no forceps were applied to portion being removed.

Each scissors cut is horizontal in plane after superior pole is cut. That is, plane of scissors cut is parallel to long axis of body, and forceps is applied to part of gland to be left in.

For each forceps applied, Crotti uses one slip of scissors. That is, the scissors only cut the amount of tissue caught in the forceps, and no more.

Upward traction is used during the transfrontal resection part of the operation. This causes the cut to gape and shows where next to apply forceps, etc. All gland to be removed is completely resected before ligatures are applied. Of course, the silk ligature is applied to superior pole before any resection of gland occurs.

The portion to be resected being removed he now applies iodine catgut ligatures to all parts included in forceps bite. He was careful to resect the pyramidical process with the part removed.

6. He now again ligated the Superior Pole. This time he used catgut. He applied the ligature in this case over the four forceps; also, before removing the forceps from superior pole he threw a catgut ligature around it.

7. In cases of oozing and difficulty of hemostasis, he used a running suture, taking off forceps only as the ligature included the part held by them, and when suture was finally tied, the oozing stopped.

(If during the operation the patient's breathing is bad it may be due to weight of all the forceps. This, however, is easily corrected and breathing will again become normal.)

8. The ligatures being tied, he finished by closing median incision, putting in a glass drain. The raw surface of the gland

was left uncovered by anything but the above closure of median incision. In the final closing he sewed the platysma by itself; the skin was then drawn together by the intradermic suture.

(The gland left in after a transfrontal resection reverts to the normal type.)

9. In dissecting gland off a trachea he makes upward traction on gland; that is, traction in such a way as to tend to lift the gland off the trachea. While doing this he inserts closed "Mayo" scissors from feetward to headward, parallel to trachea, between the ligaments of the thyreoid and trachea; he then opens the blades. This strips the gland off the trachea; thus injury to trachea is avoided.

10. Dr. Crotti then hunted for thymus gland as he always does. When he finds thymus he removes it.

(*a*) In dealing with intrathoracic goitre he first completely frees the superior pole on the side on which is the intrathoracic portion. The extrathoracic part is first resected. The intrathoracic part is then lifted out quite easily by means of "Coopers" pulling up and outward towards the head. The remainder of operation is the same as before described.

(*b*) "It is impossible," says Crotti, "to remove an intrathoracic goitre without first completely freeing the superior pole and resecting the cervical part of gland on the side of which is the intrathoracic portion of gland."

(*c*) The goitre is always removed in one piece. This is the more elegant way.

(Right side goitre apt to be large, and left side thymus apt to be large.)

(*d*) Dr. Crotti's record time for removing a goitre is from six to ten minutes. The operation all told takes about three-quarters of an hour.

(The "Cooper" is a silk tractor applied to gland with a blunt ligature carrier. Being blunt it avoids injury to vessels.)

The "Cooper" is put through the gland any place in the part to be removed; the common carotid artery being protected by the finger.

Uses of the "Cooper."

1. To pull gland upward from wound.
2. To drag *down* on superior pole.

3. To drag *up* inferior pole.
4. To aid in dislocating intrathoracic portion.

Advantages of the "Cooper."

1. Allows of a small incision.
2. Allows easy dislocation of gland; also, while the "Cooper" is used there is less necessity for cutting across the muscles.

Advantages of the Crotti method of transfrontal resection of Thyreoid Gland.

1. It allows of a general view of the whole gland and no part of the diseased portion escapes notice.
2. Relapses are less apt to occur.
3. It is ideal from an aesthetic point of view.
4. In his method we keep away from the *danger zone* and protect it by leaving enough gland tissue over it to prevent hypothyreoidism.
5. Fine invisible scar. By use of "Coopers" the scar is even shorter and in most cases it avoids need of cutting across muscles.
6. The method is simple.
7. After the transfrontal resection the remaining gland reverts to the normal type.

For anesthesia Crotti uses oxygen and ether. He tried nitrous oxide, but had bad results from it.

THE SURGICAL PERSPECTIVE IN OBSTETRICS

John Hunter, M.B., Toronto.

In a very vital sense the passage of the fetus through the parturient canal can be called a surgical operation. It is true, under normal conditions, that no artificial aid is required, but it is equally true that a mass of matter which, if retained too long, would become a veritable, and also a morbid, foreign body, is expelled from the uterine cavity as effectively, as when taken out in a Cesarean section. A greatly distended uterus is emptied, and the displaced contents of the abdomen resume

their normal position just as they would do after the removal of a large abdominal tumor.

A clear perspective of the expulsion of the fetus as a surgical operation would prove of inestimable value to both the art and the science of obstetrics. It would be a perpetual reminder to every one practising obstetrics to become imbued with the inspirations and aspirations of the true surgeon. It does not follow—in fact, the responsibility, and sacredness of the work undertaken, by the intelligent, conscientious obstetrician would forbid the exploiting of obstetrics as a sort of "side-line" to enhance one's fame as a surgeon. It is a fact that the medical profession is made up of human beings with all the common virtues and frailties of humanity, and it would be only natural to find, here and there, the immoral, the mercenary, or the feeble-minded, exploiting obstetrical surgery, as we find a like class amongst physicians prescribing an illegitimate amount of whiskey. These degenerates cannot be reached by any written appeal, as they never read medical journals, but *en passant* may not even the innate modesty characteristic of the medical mind permit a request to be made, viz., that the sages who meet at our "Round Table Talks" devote some energy to denouncing the morbid exploitation of surgical operations by mercenary, and popularity-seeking persons, posing as surgeons—and of proprietary nostrums as prescribed by the intellectually anemic, indolent, or feeble-minded physicians. In medicine to-day, as in our national, civic, and social life, the greatest menace is not from without, but from within. Like the German autocracy, the blatant impostor can easily be dealt with, but what can we do with the morbid conditions within our own ranks? What are we to do when a surgeon will stand in a corridor of a large hospital, and say, "There is an awful lot of rotten surgery being done in this hospital." This man does a lot of surgery himself and consequently in a position to judge of the character of the work being done. Why do our druggists tell us that the great mass of our physicians do not, will not, or cannot write prescriptions containing only standard drugs? This is just as true of the college professor, as it is of the most recent graduate in medicine. Is it not "up to" the sages that forgather for "Round Table Talks" to be

saying something, and doing something "worth while," when legitimate surgery and medicine are being so vitally menaced by some within our own ranks?

In obstetrics, as in every other field in medicine, except in special emergencies, no one is asked, or expected to, exceed his, or her limitations of knowledge, of skill, or of experience. We who belong to the "rank and file" are not called upon, especially where hospitals are available, and expert help can be quickly procured, to perform the many difficult operations incident to obstetric practice. Leaving then, when at all possible, these more difficult operations to those whose knowledge, experience, and skill specially qualify them for such work, what are the obligations resting upon any one engaged in the practice of obstetrics, and how are these to be met?

The answer will depend on the attitude taken. In perspective, is it a surgical case, or just an ordinary case in practice? Does the physician say, "Oh, it is only a case of labor. She will get through all right, and if not, I may have to give her something, or else use the forceps." Such an attitude is not a very inspiring one, and only too often leads to the neglect of many measures vital to the art and science of obstetrics. Neither a gown, or gloves are likely to be used, or even the hands made fairly aseptic. The patient is carelessly prepared, and vaginal examinations, instead of abdominal ones, are made. In brief, the whole attendance is more or less perfunctory, and altogether unscientific. Such an attitude is extremely dangerous to the patient, and so demoralizing to the medical attendant, as to prevent him from ever acquiring or deserving a good reputation.

If the perspective be that of a surgical case the whole attitude of the physician will be entirely different to that just described. He is going to a surgical operation, not to make a "stage play" of any surgical skill, but to give his patient the full benefit of the best methods and principles involved in the art and science of modern surgery. Cleanliness is stressed to the utmost. By means of external examinations the condition, position, and progress of the fetus are ascertained as accurately as possible. If a vaginal examination is necessary, the patient has to be properly prepared, and a sterile glove is used. The

position, the part presenting, the size of the pelvis, and of the fetal head, and the condition of the soft structures are sought for. The examination having been completed, and the need of any artificial aid decided upon, the obstetrician, like the true surgeon, when he has satisfied himself in regard to the morbid condition present, directs his attention to his patient to find out if she is fit to stand the strain, for the "manner of patient is quite a vital factor in prognosis."

A very brief review of these two perspectives—non-surgical and surgical—in obstetrics, by way of contrast, may bring out the distinction more vividly. It is, unfortunately, to be feared that the non-surgical perspective is the one taken by altogether too large a proportion of the rank and file in obstetric work. These enter the lying-in chamber with about as little inspiration for their task as they have for tying a horse, or cranking an automobile. Something has to be done, and they go about doing it. They call for soap and water to wash their hands and dry them on a soiled or clean towel. Ask the traditional questions, and gloveless and gownless make the vaginal examinations. They tell patient and nurse that everything is all right, rewash their hands, retire to another room, light their cigar or rather the newer token of degeneracy, the cigarette, read the papers, and engage in political, social, or civic gossip, with an occasional "look in" to see how the case is progressing. When no help has been needed, the child born, the cord tied, the binder adjusted, some directions given, and thus from case to case, the non-surgical obstetricians go. The patients that require artificial aid are more unfortunate still. Without the surgical perspective too many, and often too harsh examinations are made. Forceps—roughly, forcibly, and unscientifically applied. Brute force used—the patient being tilted up and down, or swung from side to side like a pendulum. Lacerations hurriedly "sewed up." It is the unsurgical class of work in obstetrics that forced Victor Bonney to make the statement recently, that in so far as the rate of mortality is concerned, there has been no improvement during the past seventy years in obstetric practice.

Behold what a contrast when labor cases are viewed from a surgical perspective! Cleanliness and asepsis made impera-

tive in every detail. The *tactus eruditus,* and every other specially trained sense and intellectual attribute used in making the external abdominal examination. If it is found necessary to make a vaginal examination the external genital organs are made aseptic, and with sterile glove, and delicate touch, the necessary information is obtained. When any artificial aid is required the obstetrician approaches his work as scrupulously prepared, and with the same inspirations and aspirations as those which guide our most reputable, intelligent and skilful surgeons. When all obstetric work is viewed from the surgical perspective, Victor Bonney and all other leaders in obstetrics will be found comparing the progress in this branch, with that already achieved in the art and science of surgery.

Society Proceedings

THE ROYAL SOCIETY OF MEDICINE

At a meeting of the Royal Society of Medicine Sir William Osler discussed a scheme, proposed by Surgeon-Major Dill, for the establishment of a Ministry of National Health. Sir William had not heard Major Dill's paper, but he had read with uncommon pleasure Major Dill's brave attempt to link a Minister of Health with the general practitioner. Everyone was agreed as to the urgent need of consolidating and co-ordinating the various departments now dealing with public health. Public opinion seemed in favor of a complete reconstruction, preferably, he would say, about the Local Government Board as a centre. The naturalization of medicine has of late progressively advanced in a way to indicate the possibility of devising a complete scheme. The insurance, the tuberculosis, the syphilis, the maternity and the child welfare legislations have brought the state to the door of the practitioner, and willy-nilly, he has become in some measure a civil servant. Much of this legislation had lacked effectiveness owing to a timorous regard for the fetish of local authority. There were public enemies that could never be conquered without an organization representing a general staff; and it was to be hoped that a strong Ministry of Health would not be content with a guerilla warfare against such preventable diseases as tuberculosis and syphilis. With intellectual meekness in high places the profession has too often suffered the pace to be set by organized ignorance. It would require the aggressive surgery of a hundred Horsleys to put an appreciation of what science means in medicine into the heads of some of those in control of the

money bags. For example, how many thousands a year does the King Edward Hospital Fund contribute to the pathological and clinical laboratories of the London hospitals? What is the annual budget for pathological work in each of the hospitals controlled by the Metropolitan Asylums Board—bumbledom of this type in the new Ministry of Health would only mean an exchange of the whips of Solomon for the scorpions of Rehoboam—but their hope is in the Local Government Board, which should form the nucleus of the new department. The spirit of Sir John Simon still lives. Then the war has furnished the profession with a great lever in public health matters. See to it that we have control of the handle. Upon three critical and contentious points I will speak briefly. The first and most important is: Can you imagine free-souled, self-reliant men as the executive officers of such a formidable row of inspectors, directors, administrators, secretaries and ministers as are included in Major Dill's scheme? The English general practitioner has an interesting history which someone should write. His gradual evolution during the last century may be best read in our literature from the picture of the father of Arthur Pendennis, through the novels of Trollope (Dr. Thorn), Mrs. Gaskell, Miss Martineau and George Eliot. Having absorbed the apothecary and killed dead the pure physician of the type of Erasmus Darwin and Caleb Hillier Perry, he poses but rarely practises as a surgeon, and withal remains our very bone marrow. Is a scheme possible in which he is a paid official of the State, yet independent; a civil servant, yet a free agent; the executive officer of a city or county council, yet alive to the needs of science? Would he be able to say to a fussy county inspector "None of your business" without a thought of Whitehall? Could Major Dill leave him this privilege all may be well. Some of you may remember how the Alabama student answered his wife, Isaphena, when she complained of his swearing at her—if it is not my duty, it is at least my privilege. Whatever is done leave the general practitioner the luxury of damning his superiors all up the line without the risk of losing his billet.

Frankly, I do not see in Major Dill's scheme how we are to have that competition which has played such an important role in the life of the profession for at least 2500 years, as illustrated by the budding of the free Greek towns of Damocedes—the Sir Arthur Newsholme of his day. With the whole population in a State service how is competition to be made effective? I am less worried about the choice of doctor, a rare privilege of the free-born Englishman, than about the choice of practices and patients and about the individual development of a progressive ambitious man, who loves his profession, who hates politics and who is too honest to pull wires. Evil will, I fear, be mixed with the good. How far we are from unanimity upon the working of the National Insurance Act, an unmixed curse one says; an undiluted blessing says another. A practical outcome was mentioned to me last Saturday in a town of 30,000 inhabitants. Six years ago not a doctor in the town had a motor, to-day not a doctor is without one. For what miserable mess of pottage do they sell their souls. I hear my good friend, Gordon of Exeter, murmur, well, I have twice known the panel pence start good clinical laboratories in country practice. It may be possible to work out a scheme but not, I trust, at the sacrifice of the independence of the general practitioner, and any system there should be room for the composition that refreshed alike brain and bank and makes the worth of a man in a community depend on his individual effort. The second point is the relation of the State to research. Not even the brilliant work in preventive medicine of Sir John Simon and his colleagues and successors has been able to overcome in certain quarters an invincible prejudice against State aid; it is an academic obsession peculiarly insular and Anglican. There are those present who will remember the virulent outburst at a meeting of the governing body of the Lester Institute when it was proposed to wed that somewhat sedate vestal to the National Research Committee. The unholy proposal was rejected by an enormous majority. There are no grounds whatever for this distrust. Contrariwise, there is every reason to encourage the union and a good outcome of the war has been a removal to a great extent of this

unreasonable prejudice. Cut out Lester's work, and in the field of infections practically all the first-hand discoveries made in this country have been by men in official harness, such as Griffith, Evans, Manson, Ross, Bruce, Leishman and others. The debt of the profession is one hundredfold greater to the Local Government Board for its researches in preventive medicine than to all our universities combined. The mouths of carpers have been closed by the series of splendid monographs issued during the war by the National Research Committee. It illustrates what can be done by a group of men with a good organization and an effective executive. That in these days of tribulation Sir Walter Fletcher and his colleagues have been able to accomplish so much is a source of genuine pride. What a rich store of merit they have acquired for the fresh fields and pastures new as a department of Ministry of Health. Thirdly—the hospital in the scheme—I agree with Dr. Benjamin Moore that in any place the hospital should form the unit or centre about which the general practitioners should unite, and Major Dill appeared to share this view. They are preparing for the change, and within a few years they should be a thoroughly working combination of the voluntary agencies with the State. The country hospitals, others too, have already placed their services most generously for the work in tuberculosis, in syphilis, and in child welfare. But to come into a national scheme there will have to be certain radical alterations in the arrangement of the staff. In many the tuberculosis officer, the syphilis expert, the neurologists under the pension boards, the maternity doctor, the infant welfare doctor have been recognized, and special departments opened. The difficulty will be with medicine and surgery if there are to be paid consultants attached to the hospitals. Let me speak of medicine only, as nowadays we can grow surgeons anywhere, not so the modern physician, who had to be a man of much broader gauge and is much harder to cultivate. Let us recognize frankly that in any new scheme, there must be a reduction in the number of attending physicians. To grow a good consultant in Major Dill's scheme, take a physician of thirty or thereabouts and make him a life-time man with a good

salary, give him eighty to one hundred beds with control of the out-patients and a staff of paid assistants. His job would be in the hospital from 9 to 1, seeing the special cases sent from the neighboring doctors, making the ward visit and directing the work in the clinical laboratories. The afternoon would be occupied in private consultations and in country visits at fixed rates. What a godsend such a man would be in every county! One would suffice. Even under present circumstances such men exist, but we all know that pure medicine as a study has not of late fostered in our county hospitals, some of which are still without the essential clinical laboratory. Such a man would be daily in touch with the other departments, tuberculosis, syphilis, children, and one thing he would be expected to do make the dispensary a living force in preventive medicine. He would be the centre of the social service work which makes the out-patient department the strong arm of the hospital in its relation with the public. As that pioneer, Richard Calebt, says, the dispensary work is radical, fundamental and preventive and hits the problem of disease at three vital spots, rooting out foci in families or districts by following home the clues presented in the person of the patient, checking disease in its incipiency and preventing chronic from escaping into a discouraging and vegetative existence. The very best men in the county would be glad to make this their life work, and in any national scheme I sincerely trust that the profession and the hospital authorities will deal with existing difficulties in a generous spirit. There are many other questions upon which I should like to dwell had I time, but just one other consideration. A strong Ministry of Health, backed by a united profession, could initiate important reforms which seem at present hopeless. The reconstruction of our medical schools, the destructive preliminary to rearrangement of the curriculum, the establishment of our hospitals of up-to-date clinics, a degree for London students, the abolition of the super-tax on British students by unnecessary examinations. Some at least of these reforms a strong central organization could force through the blind opposition of vested interests. These are post-bellum problems for the young men,

who will meet them with a new knowledge and with courage and confidence. It will be a pleasure for the seniors to stand by and see fairplay between them and the public, as represented by the authorities. Metabolism does not necessarily mean progress, and in the body politic it is not always easy to distinguish kata from ana. A full and free discussion such as Major Dill's paper will bring out should be most helpful if it does nothing but quiet that large and important group whom the fear of change perplexes and appals.

THE ACADEMY OF MEDICINE, TORONTO

During the past year this body has made substantial advance, as indicated in the reports submitted at the closing meeting. 132 Fellows served overseas, and twenty-eight engaged in military work at home. The clinical phase of the Academy's work was shown by two meetings, one at the Davisville Military Hospital, and the other at the military clinic at the Toronto General Hospital. The more of such clinics the better. Through the efforts of Dr. R. J. Noble a social-scientific meeting was held at the King Edward Hotel, at which Dr. L. F. Barker spoke. This is a good innovation. The publication committee request that in future each reader of a paper will give a typewritten copy to the secretary (often omitted), and that he present 100 copies of reprints of it to the Academy. It is a pity more of these papers are not published. In years to come the access to some of these unpublished papers, we fear will be impossible, through loss. Dr. Jno. Ferguson reports that the library has now over 10,000 volumes. He has given $100 as the nucleus of a rare book fund. Sir Wm. Osler has also contributed $100 as a nucleus for the restoration of the "Bovell Fund." Dr. H. B. Anderson has likewise contributed $100 conditionally. The interest on this money is to be used for the purchase of books on medicine, physiology and pathology. Dr. Alan Brown has contributed $100 for books on pediatrics. Dr. Gibb Wishart has given $200 for an historical section. There are now 502 Fellows, an increase of 106 since May, 1914. This showing ought to be eclipsed greatly during the next quinquennium. General and genuine regret was expressed by various reporters at the loss to the Academy of the late Dr. R. A. Reeve, one of its charter members.

Personals

HONORS FOR SIR WILLIAM OSLER

In celebration of his seventieth birthday, on July 12th, Sir William Osler, regius professor of medicine in the University of Oxford, was presented at the Royal Society of Medicine, Wimpole Street, London, with two large octavo volumes of essays, contributed to by more than one hundred and fifty different writers, his pupils, colleagues and friends in the British Empire and America. The essays cover a wide field, including medical history, education and research, as well as pathology and therapeutics.

Sir Clifford Allbutt, regius professor of physics in the university, took the chair, and among the company were Sir William and Lady Osler, Sir George Perley, high commissioner for Canada; Sir Donald MacAllister, Sir D'Arcy Power, Sir George Savage, Sir Wilmot Herringham, Doctor Pasteur, Lieutenant-General Sir John Goodwin, D.G.A.M.S.; Major-General Foster, and General Birkett, of the Canadian Medical Service; Sir Bertrand Dawson, Sir Anderson Critchett, Sir David Bruce, Lady Strathcona, Sir William Hale White, Major W. Francis, Dr. Charles Singer and J. Y. M. MacAlister.

Sir Clifford Allbutt, in presenting the two volumes, referred to Sir William Osler's many years of supreme service in two kindred nations and for the world. In him they saw the fruitfulness of the long inheritance of a culture which had survived to inspire and adorn a civilization which so lately had narrowly escaped the fury of the barbarian. He hoped that for many years to come Sir William would abide in his place as a Nestor of modern Oxford, a leader in the van of medicine and an example to them all. (Cheers.)

Sir William Osler, who met with a hearty reception, said in reply that the love of his life had been given equally to books

and men. The long list of contributors recalled his vagrant career—Toronto, Montreal, London, Berlin and Vienna as a student; Montreal, Philadelphia, Baltimore and Oxford as a teacher. With Ulysses he might say, "I am part of all that I have met."

Uppermost in his mind were feelings of gratitude that his lot had been cast in such pleasant places and in such glorious days, so full of promise for the future. Loving his profession and believing ardently in its future, he had been content to live in it and for it, and the moving ambition to become a good teacher and a sound clinician had been fostered by opportunities of exceptional character. The loyal support of a larger circle of men with whom his contact had been through the written word—the general practitioners of the English-speaking world—had been deeply appreciated. And if in the great struggle through which they had passed, sorrow came where she had not been before, the blow had been softened by the loving sympathies of many dear friends.

COL. A. J. MACKENZIE

Col. A. J. Mackenzie, surgeon-major of the 48th Highlanders in 1914, and who has now returned to Toronto, served as medical officer of the 15th Battalion at St. Julien. Col. John A. Currie, M.P., offered these words of tribute to Col. Mackenzie:

"As soon as I received permission to organize a Highland battalion of the 48th I returned from Ottawa to Toronto and called a meeting of the officers of the regiment. I laid the plans to organize the 15th Battalion before them, and asked them what they thought of the proposal. The first officer to speak up and endorse the proposition was Col. Mackenzie. He gave up a splendid practice to go to the war, and served as surgeon of the battalion at Valcartier, Salisbury Plains and France. No medical officer in the 1st Canadian Division was better loved than 'Aleck,' as he was affectionately called by the officers and men. A kinder heart never beat under a doublet. Day and night he watched over the men, and the freedom of the members of the battalion from disease was in a large measure due to his

care. While other battalions lost quite a number of men from the dread scourge 'spotted fever,' or spinal meningitis, which showed itself at Valcartier, and followed the men to Salisbury Plains and France, the 15th had only two or three cases altogether, in fact only one case was fully identified until after I left the battalion. This was due in a large measure to talks he gave the men on sanitation. We never halted in a village in France or Belgium but you would soon see him surrounded by a group of children, to whom he would be giving candies or cake. It was in his strong arms that Capt. Trumbull Warren died. It was his gentle hands that dressed Capt. Darling's wounds, and that during the Battle of Ypres gave first aid to hundreds of Canadians, French and British. The Canadian Army Medical Service has every reason to be proud of Col. Mackenzie, and the originals will never forget him."

LT.-COL. AMYOT IS MADE DEPUTY OF NEW DEPARTMENT OF HEALTH

Lt.-Col. John A. Amyot, M.B., C.M.G., of Toronto, a returned soldier, has been appointed Deputy Minister of the new Department of Health, the establishment of which was authorized in a bill passed by the House of Commons at the sessions just closed. Col. Amyot commenced his duties in Ottawa about August 1st.

Col. Amyot is professor of hygiene of the University of Toronto, and director of the laboratory of the Provincial Board of Health and has had wide experience in public health work.

He went overseas in May, 1915, with No. 4 Canadian General Hospital University of Toronto, and on arrival in England, owing to his well-known experience in sanitation, he was sent to France to take command of the Sanitary Section of the First Canadian Division in June, 1915. After some months there, he was placed in charge of the sanitary organization of the Canadian Corps and was, some months later, asked for by the headquarters authorities of the Second British Army, where he was appointed A.D.M.S., Sanitation, in September, 1916, taking charge of the sanitation of the area occupied by that

army, which extended from the North Sea to well below the Ypres salient and Armentieres.

He was mentioned in despatches December 31, 1917, and was awarded the C.M.G., January 1, 1918. For the last period of his overseas services he was consultant in sanitation to the Canadian forces in England and returned to Canada May 24, 1919.

PROFESSOR THOMAS S. CULLEN

The appointment of Dr. Thomas S. Cullen to the Professorship of Gynecology in the Johns Hopkins Medical School, in succession to Dr. Howard Kelly, has just been announced, and will give much pleasure to his many friends in Canada.

Dr. Cullen is the son of the late Rev. Thomas Cullen, of Toronto, who was well known in Canadian Methodism. He was born in Bridgewater, Ont., Nov. 20th, 1868, was educated in the public school and afterwards in the Jarvis Street Collegiate, Toronto. He graduated in Medicine from the University of Toronto in 1890, winning the silver medal. After spending a year as house surgeon in the Toronto General Hospital, he entered the service of Dr. Kelly, in the Johns Hopkins Hospital. His work there soon won him recognition. His rise was rapid, and in 1898 he was appointed Associate Professor of Gynecology in the Johns Hopkins Medical School and Associate in Gynecology in the Johns Hopkins Hospital.

He has made an international reputation as a surgeon, author and pathologist, and is a member of many of the leading Medical Societies both in America and Europe.

Major Howard H. Burnham, who was actively engaged at the front as Medical Officer to the 2nd Brigade Field Artillery for over two years, and was then transferred to the Westcliff Eye and Ear Hospital, Folkestone, England, has now gone to New York to devote himself to the study of the ear, nose and throat in the New York Eye and Ear Hospital.

Dr. N. King Wilson has resumed civil practice, and, will confine his attention to diseases of the ear, nose and throat, as before, at 380 Bloor Street West.

The resignation of Dr. Edward Spragge, owing to continued ill-health, medical officer of the Toronto Police Force for fifty years, was received and accepted.

for the city of Toronto, in place of Dr. Edward Spragge, who for the city of Toronto, in place of Dr. Arthur Spragge, who resigned on account of continued ill-health.

Dr. Perry Goldsmith has returned from Service Overseas, and resumed his practice at 84 Carlton St., Toronto; Diseases of Ear, Nose and Throat.

Dr. Robert G. Armour announces to the profession that he has resumed practice at 98 St. George St., Toronto, and will, as formerly, confine himself to the diagnosis and treatment of nervous diseases.

Lt.-Col. R. S. Pentecost, C.A.M.C., desires to announce on his return from overseas service, that he has now resumed his civil practice in diseases of the eye, ear, nose and throat at his offices, 90 College Street, Toronto.

Dr. H. B. Anderson begs leave to announce to the medical profession that after August the fifteenth he will devote his attention to the investigation of medical cases and consultation in internal medicine. He will have associated with him as his assistant Dr. R. W. Mann.

Obituary

DR. JAMES SALMON

Dr. James Salmon died at his home in Simcoe, Ont., on June 17th, in his ninety-seventh year. He was a native of Norfolk, and was born in 1823, having lived under five sovereigns. He graduated in medicine at the age of twenty-two, retiring from active practice eighteen years later.

DR. GEORGE STANTON

Dr. George Stanton, who for nearly fifty years practised medicine at Simcoe, Ont., and who left for Denver four years ago, died there the week of March 17th.

DR. R. J. GIBSON

Dr. R. J. Gibson, the Soo's best known physician and surgeon, died suddenly on August 5th. He was chairman of the High School Board and had been a Liberal candidate in Federal elections. For some time he was head of the Dominion Medical Council.

The Physician's Library

Diseases of the Ear in School Children. An Essay on the Prevention of Deafness. By James Kerr Love, M.D., F.R.F.P.S.G. Bristol: John Wright & Sons, Limited. London: Simpkin, Marshall, Hamilton, Kent & Co., Limited. 1919.

The book is a review of three years' work in the Glasgow school clinics, and is a record of the progress made in the treatment of ear diseases during the school period, the work being carried on by trained workers, and an efficient "follow-up" system being inaugurated.

The writer also outlines a scheme of classification of the deaf for educational purposes, and devotes a chapter to syphilis and heredity as causal factors in deafness.

The title of the book might almost be said to be misleading, for, as stated in the preface, it is essentially an essay on the prevention of deafness, dealing little with the clinical aspects of the cases treated.

Essentials of Surgery. A text-book of surgery for student and graduate nurses and for those interested in the care of the sick. By Archibald Leete McDonald, M.D., of Johns Hopkins University. J. B. Lippincott Company. Philadelphia and Montreal. 1919.

For the student or graduate nurse who desires to broaden her understanding of surgical conditions met with in the care of patients, this book presents in a clear concise manner salient points in the study of surgery which will prove most instructive and interesting. It is illustrated by original drawings and contains a glossary of essential medical terms. A chapter dealing

with "Wounds, Hemorrhage, Surgical Operations and Anesthesia" is most valuable and contains many practical hints. Although this book is written in plain language, it is not intended as a book of reference, nor does it deal with technical nursing methods.

Vicious Circles in Disease. By JAMIESON B. HURRY, M.A., M.D. (Cantab.). With illustrations. Third and enlarged edition. London: J. & A. Churchill, 7 Great Marlborough Street. Price, 15s. net. 1919.

Until one reads this book he has little idea of the frequency of vicious circles. For many years "Vicious Circle" has been a stock phrase in medical circles, but little has been said about the breaking of the circle and the establishment of a virtuous circle in its place. There are 22 chapters in the book. Circles in all the bodily systems are considered seriatim, and of all the special senses; also in plants and animals. There is a study, too, of artificial circles. How nature breaks the circle and how it may be broken by hygienic means, by drugs and surgical appliances and operative procedures concludes a unique book.

An Outline of Genito-Urinary Surgery. By GEORGE GILBERT SMITH, M.D., F.A.C.S., Genito-urinary surgeon to Outpatients, Massachusetts General Hospital. 12mo of 301 pages with 71 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, $2.75 net. Canadian agents: The J. F. Hartz Co., Ltd., Toronto.

The title of the book suggests that a general outline of diseases of the genito-urinary organs will be found therein, the author stating in his foreword that the book was written for students and general practitioners. It might better have been named, "My Views on Genito-urinary Conditions." Most of the conditions are treated in a very superficial manner, and the general practitioner will find little material which is not dealt with more fully in works on general surgery. Many cases cited are so typical of textbook description that there seems no particular reason for giving them in detail. The illustrations are

clear and well reproduced, although one of these on page 250 is upside down. With the number of books available on this subject, there would appear to be but little reason for the publication of such a book.

The Pituitary. A study of the morphology, physiology, pathology, and surgical treatment of the pituitary, together with an account of the therapeutical uses of the extracts made from this organ. By W. Blair Bell. New York: William Wood & Company. 1919. Price, $7.50.

Every physiological worker will eagerly read this book to compare Bell's experimental work on animals with his own. His technique is clearly presented and the illustrations are beautiful. Chapters respecting the relation of the pituitary and its secretions to the other hormonoporetic organs are very interesting at this particular moment when so many thyroids are being sacrificed and so much pitualarin administered. Every obstetrician should read the chapters on the use of the extracts from the pars anterior and the pars exterior, so that he may more intelligently use this potent drug. Blair, of course, does not give any final statement on the influence of one endocrine organ on another, and we shall await his further work with much interest.

The American Hospital of the Twentieth Century. A treatise on the development of medical institutions, both in Europe and America, since the beginning of the present century. By Edward F. Stevens, Architect, Member of the American Institute of Architects, Member of Province of Quebec Association of Architects, Member of American Hospital Association. Illustrated. New York: The Architectural Record Publishing Company. 1918.

Mr. Stevens has presented in this volume of 274 pages, on calendered paper, plans of a number of the newer European and American hospitals, the latter of which include a number planned by himself, together with a limited amount of descrip-

tive text, descriptive of the plans. Chapters are devoted to the administration department, the ward unit, the medical and surgical units, the maternity, contagious, psychopathic, tuberculosis, social service, out-patient, pathological and X-ray departments; the children's hospital; the small hospital; the nurses' residence; kitchen and laundry; heating, ventilating and plumbing, detail of construction and finish; equipment, landscape work, and war hospitals. The author presents here the results of his observations of many institutions on both sides of the Atlantic during recent years, and his efforts in giving to the hospital world this volume—the work of off-hours in a busy life—must be highly commended.

BRITAIN MAY EXTEND MEDICAL AID TO ALL

It was recently stated that changes in England's system of medical service whereby the "panel" plan now applicable to the poor would be extended to all classes are proposed by a Government committee. Many physicians are strongly opposing the proposals.

For a number of years, under a health insurance act, wage-earners have been called upon to make a small weekly payment to a fund which the Government uses to provide medical attention for all classes of the population affected by the insurance law. Every practising physician must treat a certain number of the so-called "panel" patients, receiving pay for this work from the Government. The new scheme provides for whole-time medical service, and practitioners entering it are to be graded into five classes as corresponding to military rank, ranging from lieutenant to colonel.

Class 1 would be paid $7,500 a year, Class 2 $5,000, and so on down to Class 5, which would be paid $2,000. Examinations would be held for promotion to higher classes. Expenses incurred by the practitioner for drugs, appliances, clinics and travelling expenses would be paid by the Government.

Each physician would be expected to look after between 2,000 and 3,000 patients. The higher classes of medical men would deal chiefly with administrative work, and with the giving of consultative advice.

Publisher's Department

IODINE IN THE TREATMENT OF PARASITIC DISEASES OF THE SKIN

One of the largest and most important sections of dermatological therapeutics is concerned with the treatment of local infection of the skin. In some cases the infective agent or parasite is microbic, as, for example, in that common condition—almost universal among children of the hospital class—impetigo; and in boils and furuncles, almost equally frequent in occurrence; and in acne vulgaris—not to speak of rare microbic diseases of the skin which hardly enter into everyday practice.

Another large class of infections are those due to the more highly organized vegetable parasites known as fungi. Most of those, which are of dermatological interest, are included among the various species of ringworm; other fungi, rarer, but of considerable interest, are the favus group, the streptothrix group, and the sporothrix family.

These local infections of the skin vary greatly amongst themselves in the way in which they respond to local treatment with antiseptics. Some of them are exceedingly easy to deal with, because they are superficial in character and do not penetrate to the deeper layers of the dermis.

There is, however, another type of case which is more difficult to control, that is when the infective agent, whether it be microbe or fungus, is deeply situated, and is therefore inaccessible to the action of antiseptics applied to the surface. The most common and troublesome examples of this type of case are those in which the hairy parts are infected, and the infective agent is seated either in the deeper parts of the hair itself or at the bottom of the hair follicle.

Every practitioner knows from painful personal experience how troublesome these conditions are to treat. Even the X rays,

to which many patients or their parents have a more or less reasonable objection, are not absolutely certain in effecting a cure.

In these cases the desideratum is an antiseptic of superior penetrating power. The necessity of this power will be seen when it is realized that a hair follicle is often quite a quarter of an inch long, and therefore the active principle of the antiseptic application used must be able to penetrate at least this distance. It is here that the superior antiseptic and antiparasitic properties of Iodine are desirable. Preparations of Iodine have long held some reputation for their power in controlling ringworm of the scalp and sycosis of the beard. Particularly in early cases the official linimentum iodi has been used with some success in treating a patch of ringworm of the scalp, and it has several times been recorded that old-standing cases of pustular sycosis of the beard have been cured by iodine of sulphur ointment.

Unfortunately, these older remedies are by no means certain in their effects, and linimentum iodi is often quite useless in an old-standing case of ringworm. This is not surprising, because the preparation is not in a form in which it can be rubbed in, and thus its penetrability is limited. In any case it is a messy and unsightly method of treatment owing to the thick brown crusts which are formed. It is also painful, and for that reason parents are often reluctant to persevere with the application energetically, an additional common cause of failure.

Occasionally, linimentum iodi has been tried for sycosis of the beard, but here it certainly cannot be recommended, both on account of the cosmetic disadvantages which attend it and also because the skin of the face is far too tender, and often a severe inflammatory reaction is caused.

The only preparation of iodine which gives any real satisfaction is Iodex. This, as is now usually known, consists of iodine presented in a neutral base in such a manner that the natural disadvantageous features of the drug, always undesirable, are absent. It forms a convenient non-staining and non-irritating ointment.

Recently far better results have been obtained from its use both in ringworm of the scalp and in sycosis of the beard than

from any other form of local application. Single patches of ringworm have been cured by the persistent and careful inunction of Iodex into the scalp, on several occasions within six weeks, and one particularly gratifying case of ringworm of the beard combined with ringworm of the glabrous skin should be mentioned, which was cured within two months. The patch on the skin disappeared within a fortnight. This, however, was not so remarkable a testimony to the efficacy of the remedy as the cure of the beard infection, for this is usually just as persistent in a man as ringworm of the scalp in a child. Good results have also been obtained in staphylococcic sycosis of the beard, a most obstinate condition, which often persists for years notwithstanding painstaking treatment with ointments and lotions, and even with X-rays and vaccines. Several cases in which there has been a single patch on the chin or on the upper lip for a considerable period before coming under observations, have yielded to Iodex within a few weeks, and it has also proved very useful in those still more troublesome patients in whom the whole area of the beard has been affected and in which the infection has spread even to the eyebrows and eyelashes.

Perhaps, however, one word of warning is necessary. Some individuals are unfortunately particularly susceptible to iodine, even when presented in a form that is comparatively bland in action, and in one case where there were no longer pustules, but the whole infected area was in an eczematous condition, the inunction of Iodex was followed by a rather acute exacerbation, inflammatory in character, involving to some extent the other parts of the skin. This condition, however, yielded quickly to ordinary soothing treatment, and after its subsidence left the original complaint much improved.

POINTS TO BE CONSIDERED IN MAKING AN INVESTMENT

In making an investment, the first, and certainly the most important, consideration is the safety of the principal. No person can afford to lose, and, therefore, no person should take any unnecessary risk. The same principle applies to purchases by professional men of securities which are to be left to their wives and dependents. The rule of "safety first" should be followed

very strictly. There are hundreds of bonds and stocks which, under existing business conditions, are perfectly safe, but which, under conditions which have existed for the past five years, might not have been so considered. Hence a doctor, as far as possible should pick out securities which are considered safe under any conditions. In leaving securities to posterity, there is of course no way to guard against changes in the worth of capital, but other available precautions may be taken. Bonds should be selected which have in them the elements of permanent value. These elements are, first, abundance of physical assets, and, second, stability of assets. What not to buy is perhaps just as important a question as what to buy. As a rule, the more your bond yields over 5 per cent. the greater the risk assumed, and the more it yields below 5 per cent., the greater is the excess of physical assets underlying the bond over and above its market value. The bonds or debentures issued by the Canada Permanent Mortgage Corporation, Toronto, are worthy of careful consideration. They possess in a very special degree all the elements of permanence which those eminent authorities enumerate as necessary to insure the absolutely essential consideration of the safety of principal, being thus placed in the very highest class of securities suitable for investment purposes. Any physician with a thousand dollars or more to invest should look carefully into the debentures of this corporation.

BLENOSAN CAPSULES

The routine treatment of urinary diseases, notably Gonorrhea, Urethritis, Cystitis, have in the past presented grave difficulties to the medical profession. The difficulty has been that a dependable specific embodying the highest efficiency, accurate dosage, and purity, have not been met in any one capsule, until a few years ago Messrs. Robert Ferber, Ltd., of 110 Church Street, Toronto, Canada, carried out costly and protracted experiments to ensure the production of a preparation combining these three essential properties. A model

factory was equipped at great expense, and efficient staffs secured to carry out the high ideals which were recognized as being absolutely essential in the production of an article of this description. Success has attended the efforts of the proprietors; so much so that further extensions have been necessary to their laboratories; and now that the supplies of first quality East Indian Santal Wood Oil is available, work is proceeding at high speed to cope with the ever-increasing demands. The claims of Blenosan Capsules have been more than justified, and physicians have found this to be an entirely dependable product for many reasons. Amongst others, it carries out its work speedily, and traces have been found in the urine within a short time of administration. The gelatine used for the Capsule is elastic and particularly soluble, ensuring as it does that the contents do not pass undistributed through the body. Only the finest East Indian distilled Santal Wood Oil is used in the manufacture of Blenosan Capsules, and great care is given to ensure accurate dosage. Altered conditions brought about by the Great War have rendered it the care of each Government to see that efficient measures are taken to cope with venereal diseases, and physicians cannot do better than to secure and prescribe Blenosan Capsules if the best treatment with the safest and quickest results are to be secured.

PROPHYLAXIS OF INFLUENZA

If we may judge the future by the past, there is likely to be a recurrence this fall and next winter of the influenza epidemic which resulted in the death of nearly half a million persons in this country a few months ago. In the event that this forecast proves true, what can physicians do to limit the spread of the disease and lessen its terrors?

Immunization with a reliable vaccine would seem to offer the best solution of the problem. Clinical reports on the use of preventive vaccine, as published in various medical journals in recent months, warrant this conclusion. The following instances are here cited:

In the *Kentucky Medical Journal* for May, 1919 (page 199), the editor says: "The reports from some three hundred thousand cases indicate that the vaccine (Rosenow) decreases influenza, almost entirely prevents pneumonia, and in practically no case where it was used had death occurred."

In the *Canadian Medical Association Journal* for June, 1919, Major F. T. Cadham, C.A.M.C., reports his observations on the use of preventive vaccine in the influenza epidemic in Winnipeg. He says: "I believe the vaccine used as a prophylactic for the members of the Canadian Expeditionary Force of this district to have been of value. The incidence of pneumonia was less than one-half and the mortality rate less than one-fourth in the inoculated, as compared with the uninoculated, admitted to the special hospital under similar conditions."

HYPERTENSION

Hypertension holds first place as a cause of arteriosclerosis. And no age is exempt from the lesions of arteriosclerosis. The lesson is obvious: By the early detection and reduction of high blood pressure, ward off the evils of arteriosclerosis. Remove, of course, the underlying conditions that produce high tension. But, it is not always wise to wait for this rather slow alternative procedure; often one must symptomatically reduce the pressure in the meantime, to relieve the strain on the vessels. For this purpose Dr. M. C. Thrush has devised a combination of nitre salts with sodium bicarbonate (since acidity is practically always an element in high blood pressure) and crataegus oxyacantha, under the name of Pulvoids Natrium Compound, which is marketed by the Drug Products Co., of New York. The inclusion of a heart-muscle tonic prevents possibility of cardiac shock, and a special form of coating, insuring disintegration of the tablet in the intestines, prevents kidney disturbance. These tablets are both economical and efficient, which is some combination these days. Samples and literature can be promptly secured from R. L. Gibson, 88 Wellington St. West, Toronto, Canadian Agent.

THE VACCINE TREATMENT OF DIABETES

Diabetes has been considered an obscure functional disease for such a long time that it is somewhat difficult to associate it with an infection and, consequently, amenable to vaccine therapy.

From a closer study of sugar metabolism it has been demonstrated that this function is maintained by internal secreting organs, which secrete a substance that has the property of converting sugar into glycogen so it can be stored and utilized as required; and that this function is largely, if not entirely, performed by the pancreas, more particularly the islands of Langerhans in the head of the pancreas, and that in diabetes these secretory organs are disturbed or destroyed.

That inflammation of the pancreas is very closely associated with diabetes is now quite generally recognized. Max Einhorn (*Journal A.M.A.*, July 10, 1915, p. 149), points out in a critical analysis on pancreatitis that Opie contends that the islands of Langerhans are diseased in 85 per cent. of diabetes cases and that generally a diagnosis of chronic pancreatitis can be made out.

Dr. G. H. Sherman, of Detroit, Michigan, has done considerable original work on the subject of diabetes and has arrived at new and interesting conclusions.

He will be very pleased to send data and give any information at his command to those interested.

LET'S BE READY

Foresighted physicians all over the country are "girding up their loins" for a decisive battle with epidemic influenza, if it again makes its appearance. They are getting ready to crush the very first efforts of the "flu." to re-establish itself, basing their attacks upon the therapeutic agents which proved most effective last season. Chief among these is Calcidin, and the fact that it will be used to even greater extent this year is shown by the large advance orders already received, according to The

Abbott Laboratories, who produce Calcidin. The following letter from an Illinois physician is typical of many:

"I treated 983 cases of "flu." and used Calcidin on practically all of them. In fact I saturated them with it and lost only one case. I treated them the same as the rest of the doctors, but they did not use Calcidin, and that is the only thing I lay my good success to. I want to stock up and get ready if the epidemic hits us again."

Whether another epidemic hits us or not, Calcidin is the dominant remedy in colds, coughs, croup, grippe, pneumonia, and influenza. It is the physician's chief support in winter ailments.

If you are not acquainted with Calcidin (Abbott), samples will be gladly furnished upon request to The Abbott Laboratories, Chicago, Ill.

THE "TYCOS" SELF-VERIFYING SPHYGMOMANOMETER

Physicians who have once used a "Tycos" never use any other make. Why? Because it invariably gives satisfaction. One of the most important advantages, however, of the "Tycos," is that it *proves its readings*. It has no adjustments and requires no checking. If the pointer returns to zero, the reading is correct. Any physician desiring a demonstration will be given one on application to any dealer.

McCRIMMON'S FLUID

This is a preparation of remarkable potency and is meeting with the endorsement of many physicians. In the treatment of Poison Ivy, it is most efficacious. As a spray in cases of Pharyngitis, as a wash in indolent ulcers, it gives rapid relief. When used in the operating room and hospital ward, it will be found second to none as a germicide and antiseptic.

AN IDEAL RESORT FOR CONVALESCENT PATIENTS

Physicians have frequent opportunities of referring those convalescing from illness to a resort where they can quickly recover their old-time vigor and enjoy an almost ideal climate, 2,500 feet above sea level. Such a resort is Virginia Hot Springs, just one night out of New York. The management have spent a huge sum of money on this choice spot in "Old Virginny," and are anxious that the Canadian medical profession should continue to refer cases there, as they have done in years gone by. The Homestead Hotel is one of the handsomest houses in America. It is built of solid brick, containing 500 guest rooms, with many parlor suites and 300 private baths. It is spacious, dignified, quiet and restful, with magnificent mountain views on every side. It is no exaggeration to say that Hot Springs means the Homestead Hotel. The Company owns 5,000 acres surrounding the hotel, so that physicians can understand that their patients have every opportunity of enjoying outdoor life and regaining thereby their normal strength.

The dominant factor making Hot Springs world-famous is the cure in which the climate as well as the water assist. The waters are conducted by gravity to the bathhouse and distributed fresh from the ground to the bathing apartments on different floors without loss of heat or its increase by artificial means, and fully charged with all their gases and other health-giving qualities. At none of the celebrated places in Europe, and at no other springs in America, is the temperature prescribed for hot baths that at which the water actually emerges from the earth in the natural springs.

The springs are beneficial, not only for bathing, but for drinking. Besides the hot springs, the effects of which as drinking waters are pronounced, there are magnesia, sulphur, and soda springs within the grounds, and alum water from a spring not far distant. The water from the soda spring comes strong and clear from the ground at a uniform temperature of 74 degrees. Physicians should address for full information Christian S. Andersen, Esq.

The Canadian Journal of Medicine and Surgery

A Journal published monthly in the interests of Medicine and Surgery

Vol. XLVI. TORONTO, NOVEMBER, 1919 No. 5

Editorials

MEDICAL, DENTAL AND NURSING WORK IN WEST CHINA

ABOUT mid September the Board of Governors of West China Union University, representing five constituent denominations, convened in Toronto. A great many very important questions were dealt with by the Board, especially looking toward large developments of the institution in the future. Great stress was laid upon the importance of promoting medical, dental and nursing instruction, for China is especially weak along these lines.

Victoria College took advantage of the occasion to give a dinner to the members of the Board, in order that they might meet with some of the leading doctors and dentists of the city, together with other guests.

The great theme of the occasion was the consideration of an enlarged scheme of professional education in connection with the Chengtu University,

which the three professions of medicine, dentistry and nursing in Canada and Newfoundland, are being asked to specially provide for. A central committee has already been formed in Toronto and every member of these professions in this country will be circularized and invited to co-operate in a movement which must mean large developments in medical, dental and nursing instruction among the one hundred millions of Chinese, aborigines and Thibetans in West China.

Rev. Dr. Goucher, Chairman of the Board of Governors, sketched the scope and outlook of the University, and its immensely strategic position; and Rev. Dr. Beech, the President of the University, followed with a lucid survey of its rise and development, illustrating it most convincingly by the exhibition of some beautiful lantern slides showing buildings and groups of students. These pictures visualized the institution and impressed all with its wonderful progress since its beginning ten years ago, and also with its possibilities for a great future.

Dr. C. W. Service, of Chengtu, was then called upon to make a statement as to the medical needs of China. He urged that fully 99 per cent. of China's need for doctors and nurses and almost 100 per cent. of her need for dentists have still to be met. He stated that the proposal for enlisting the healing professions of Canada and Newfoundland in an effort to secure more adequate facilities for training Chinese doctors, dentists and nurses would do much to help meet these dire needs.

Dr. N. A. Powell, in a brief but earnest address, spoke on behalf of the members of the medical profession, promising hearty sympathy and co-operation.

Dr. A. E. Webster, Dean of the Royal College of Dental Surgeons, enthusiastically seconded Dr. Powell's address, making mention of the fact that four of the dental surgeons of China were graduates of the institution now under his care, and that three of these, Drs. Lindsay, Thompson and Mullett, are now in Chengtu, engaged in the practice and teaching of dentistry.

The meeting was a most encouraging send-off for the new project and it seems certain that the medical, dental and nursing professions of Canada and Newfoundland will rally splendidly to give West China a measure of the privileges in skilled men and women and scientific facilities for their work that Canada enjoys so bountifully.

Those present included the following: Board of Governors of West China Union University—Revs. Dr. Goucher, Dr. Franklin, Dr. North, Dr. Rice, Dr. DeBlois, Dr. Beech, Messrs. Williams, Wood, Hunt, and Vaux, all from U.S.A. Also Revs. F. Anderson, Dr. Endicott and Chancellor Bowles, of Canada. Physicians and Surgeons: Drs. N. A. Powell, S. M. Hay, J. N. E. Brown, F. N. G. Starr, C. P. Lusk and A. C. Hendrick. Dentists: Drs. A. E. Webster, F. F. Price, H. E. Eaton, J. A. Bothwell, W. E. Willmott and W. A. Black. Prominent business men, among them Messrs. E. R. Wood, H.

H. Fudger, J. H. Gundy and Vincent Massey. Prominent city ministers, including Rev. Dr. Gandier of Knox College. Missionaries from West China and Japan.

MINISTER OF HEALTH

THE appointment of Dr. John Amyot as Deputy Minister of Health, has met with general approval. He has a big field. Seeing that the public health situation has up to the present been largely a provincial problem, the advent of a Federal bureau must bring about a fresh orientation on this most vital national branch of public welfare.

We do not know what Dr. Amyot's primary plans are; we would suppose that a general national conference, composed of public health workers and students from all parts of the Dominion would be a good initial procedure, or, seeing this is a time for commissions, a small body of men specially qualified might travel throughout Canada, visiting the leading centres, and make a survey of the whole situation—that is to say—the water and milk supplies, sewage disposal, venereal diseases, infant welfare, housing, health of school children, food adulteration, and the several other topics relating to the general health of Canadians.

Dr. Amyot ought to be provided with a big laboratory for research work. We are just at the beginning of knowledge of bacteria and their re-

lation to disease. To mention only one or two of numerous investigations which might be undertaken—the cause of Influenza; the relation of diet to health. A special study might also be made of climatology and its practical bearing on the prevention and treatment of tuberculosis, hay fever, nephritis and other diseases in which weather plays so important a role.

This journal wishes the greatest success to Dr. Amyot.

ACADEMY OF MEDICINE

THE opening meeting of the Academy of Medicine, Toronto, for the current winter, took place in the Mining Building, of the University of Toronto, on Tuesday evening, October 7th. The feature of that meeting was the Presidential Address delivered by Dr. Edmund E. King. We regret exceedingly that, as this issue of *The Journal* was already in type, we are unable to publish one of the ablest and most practical addresses ever delivered before this body. We heartily congratulate the President upon his initial effort and feel strongly that the Council of the Academy should consider calling a special meeting of the Fellows, thereby giving them an opportunity of freely discussing several of the topics to which allusion was made. We think that we are not far astray in stating that seldom has any President spoken as courageously on subjects of vital import-

ance to the profession of the Province. We heartily endorse all Dr. King said as to some necessary amendments to the Workmen's Compensation Act in its relationship to the profession; the undignified position in which the Profession has been placed in being appointed "official bartenders" for the Province under the O.T.A., the action of the Ontario Government in having done nothing with the able report of Mr. Justice Hodgins, and the action of the Nurses' Association in demanding that eight hours be considered a day's work.

Canadian Journal of Medicine and Surgery

Editors

Surgery:

N. A. Powell, M.D., C.M., Professor of Medical Jurisprudence, Medical Department, University of Toronto; Senior Assistant Surgeon in charge, Shield's Emergency Hospital.

Clinical Surgery:

Alex. Primrose, M.B., C.M., Edinburgh University; Associate Professor of Clinical Surgery, Toronto University; Secretary Medical Faculty, Toronto University; Surgeon Toronto General Hospital; and Herbert A. Bruce, M.D., F.R.C.S., Eng., Surgeon, Toronto General Hospital.

Orthopædic Surgery:

W. E. Gallie, M.D, Associate Surgeon, Hospital for Sick Children, Toronto; Clarence L. Starr, M.B., Associate Professor of Clinical Surgery, University of Toronto; Surgeon-in-Chief of the Hospital for Sick Children, Toronto; Consulting Surgeon to Toronto General Hospital; H. P. H. Galloway, M.D., Orthopedic Surgeon, Winnipeg General Hospital; Lecturer in Orthopedic Surgery, Manitoba Medical College; Member of The American Orthopedic Association.

Militia and Naval Medical Services and Ambulance:

J. T. Fotheringham, M.D.; C.M.G.; Colonel, Army Medical Corps, Associate Professor of Medicine and Clinical Medicine, University of Toronto; Associate Collaborator, Chas. J. Copp, M.D., C.M., Hon. Sec. Provincial Council of Ontario, St. John Ambulance Association.

Medical Jurisprudence and Toxicology:

Arthur Jukes Johnson, M.B., M.R.C.S. Eng., Coroner for the City of Toronto; Surgeon Toronto Railway Co., Toronto; W. A. Young, M.D., L.R.C.P., Lond., Ex-President of the American Medical Editors' Association; Associate Coroner, City of Toronto.

Hospital Administration:

Mrs. Amy A. Armour Smith, R.N., New Rochelle, N.Y., Ex-Superintendent, New Rochelle Hospital, New Rochelle, N.Y.; A. K. Haywood, M.B., Toronto, M.R.C.S., L.R.C.P., London, Medical Superintendent Montreal General Hospital.

Pediatrics:

Allen Baines, M.D., Toronto; Associate Professor Pediatrics, University of Toronto; Physician, Hospital for Sick Children; Helen MacMurchy, M.D., Toronto.

Medicine:

W. J. Wilson, M.D., Toronto, Physician, Toronto Western Hospital; J. H. Elliott, M.D., Associate Medicine and Clinical Medicine, University of Toronto; W. H. Pepler, M.D., Junior Medical Assistant, St. Michael's Hospital; and A. J. Harrington, M. D., M.R.C.S., Eng., Toronto.

Clinical Medicine:

Alexander McPhedran, M.D., Professor of Medicine and Clinical Medicine, Toronto University; Physician, Toronto General Hospital; Lewellys F. Barker, M.D., Professor of Medicine, Johns Hopkins University, Baltimore, Md. H. B. Anderson, M.D., Toronto; Associate Professor of Clinical Medicine, University of Toronto.

Mental and Nervous Diseases:

N. H. Beemer, M.D, Mimico Insane Asylum; Campbell Meyers, M.D., M.R.C.S., L.R.C.P. (London, Eng.), Private Hospital, Deer Park, Toronto.

Gynecology and Obstetrics:

B. A. Watson, M.D., Edin., F.R.C.S., Edin., Professor of Gynecology and Obstetrics, University of Toronto; Gynecologist and Obstetrician, Toronto General Hospital; Geo T. McKeough, M.D., M.R.C.S., Eng., Chatham, Ont.; C. F. Moore, M.D., Toronto; and A. C. Hendrick, M.A., M.B., F.R.C.S. Edin., Demonstrator in Gynecology, University of Toronto; Assistant Gynecologist, Toronto General Hospital.

Pathology:

J. J. Mackenzie, B.A., M.B., Professor of Pathology and Bacteriology, University of Toronto; H. K. Detweiler, M.B., Assistant Pathological Dept., University of Toronto.

Ophthalmology:

J. M. MacCallum, M.D., Toronto, Senior Assistant Eye Department, Toronto General Hospital; Oculist and Aurist Victoria Hospital for Sick Children, Toronto. Walter W. Wright, M.B., Assistant in Ophthalmology, Toronto General Hospital and Hospital for Sick Children.

Nose, Throat and Ear:

Perry G. Goldsmith, M.D., 84 Carlton St., Toronto, Laryngologist and Aurist, Provincial Institution for the Deaf and Dumb; Senior Assistant Ear, Nose and Throat Department, Toronto General Hospital.

Dermatology:

D. King Smith, M.B., Tor., Toronto; Demonstrator in Pathology, Toronto General Hospital

Managing Editor:

W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont.

Address all Communications, Correspondence, Books, Matter regarding Advertising, and make all Cheques, Drafts and Post-Office Orders payable to "The Canadian Journal of Medicine and Surgery," 145 College Street, Toronto, Canada.

Doctors will confer a favor by sending news, reports and papers of interest from any section of the country. Individual experience and theories are also solicited. Contributors must kindly remember that all papers, reports, correspondence, etc., *must be* in our hands by the first of the month previous to publication.

Reprints supplied at Net Cost

Original Contributions

SURGICAL EFFICIENCY IN AN ARMY MEDICAL SERVICE

By Herbert A. Bruce, M.D., F.R.C.S. (Eng.)

Colonel British Army Medical Service and C.A.M.C.; Associate Professor Clinical Surgery, University of Toronto; Surgeon to the Toronto General Hospital.

One of the most urgent needs of all the countries engaged in the great European war just finished, was *surgeons* and still more *surgeons*. As the supply of skilled surgeons was necessarily limited and never sufficient in the front areas when a battle was on, the problem of making full use of those available was a very pressing and important one. The enormous improvements in the results obtained by early "debridement" of the wounds in the casualty clearing stations, as compared with later operations in the base hospitals, not only in the healing of the wounds and the possibility of primary suture, but in the incidence of gas gangrene, was so striking as to impress upon Sir Anthony Bowlby and the other consultants of the British service, the great importance of increasing the number of surgeons in the casualty clearing stations, so that all the wounded could be operated upon there if possible. This was the ideal to be aimed at. However, it never became possible of fulfilment during the early period of a big engagement and entirely broke down at the time of the great German offensive of March, 1918.

The organization of surgical teams in the early part of 1917 by the British Medical Service marked a great step in advance in the development of surgical efficiency in the front areas. These teams at first consisted of a surgeon, an anesthetist, a nurse and an orderly, later of two nurses and two

orderlies, a total of six. These teams were mobile units made up in base hospitals and sent up to casualty clearing stations the day before we expected to attack, or were called up when the Hun commenced an offensive.

The normal staff of a casualty clearing station provided only two surgeons and was sufficient only for peace times, but during attacks this had to be supplemented by eight or ten visiting teams. The great advantage of these mobile surgical teams was that they could be moved quickly to any part of the line where increased activity occurred. In order to still further increase the amount of work the surgeon could do, two operating tables were provided for each surgeon, so that he might be constantly employed and not kept waiting while the table was being cleared and another patient put on it. In order to utilize the special skill of the surgeon to the fullest extent he should be relieved of the necessity of helping to prepare the patient and many other things which could as well be done by unskilled help.

In the American service so-called "splint teams" were organized, made up of men specially trained in the application of splints, so that as soon as the surgeon had finished his operation on a fractured limb the patient was turned over to specially trained men to have the splint applied.

The Director-General of the British Medical Service on the recommendation and advice of the Consulting Surgeons in October, 1917, arranged to have a certain number (250) of nurses trained to give anesthetics and to use them in the various hospitals and on surgical teams, thus releasing a similar number of medical officers for other duties. These trained nurse anesthetists rendered splendid service in the great rush of casualties following the offensive of March, 1918. Their employment from this on gave such good results that regret was felt that they had not been used earlier in the war.

I am able to take some credit for their employment in the British army, as I had urged it upon the Director-General of the British Medical Service some time previously, but what really made this epoch-making change possible was the wonderful work of the American nurse anesthetists who went over with the six hospitals sent by the United States early in 1917

to staff British base hospitals in France, and of Miss Nicholson, the nurse anesthetist with No. 3 Canadian General Hospital. Their splendid work convinced the Director-General and the British consultants of the value of women (without degrees in medicine) as anesthetists. British surgeons soon became enthusiastic supporters of nurse anesthetists, and if the war had continued there is no doubt they would have ultimately replaced medical officers in the giving of anesthetics in the British service. This would have released more than 500 doctors for other much needed work.

You are probably aware of the fact that nurse anesthetists are employed almost exclusively in the American Medical Service, and most surgeons serving in France are now convinced that women make ideal anesthetists, and their employment in increasing numbers in civil hospitals is assured. The American Medical Service also had "shock teams" consisting of men specially trained in the problems of shock, to work in their evacuation hospitals—the name they adapted from the French for the advanced hospitals which corresponded to our casualty clearing stations.

Even with a dozen surgical teams working in a casualty clearing station, it was only possible to operate upon from 16 to 20 per cent. of the casualties coming in the first day of an offensive. So that it was clear if all casualties were to be operated upon we should require four or five times the number of surgeons and a corresponding increase in the operating huts. The provision of two tables for each surgeon increased materially the amount of work he could perform.

Professional efficiency is so intimately bound up with medical organization that it is a matter of the greatest importance that all questions of a purely professional character in our medical service should be divorced from routine matters of organization and administration.

Our permanent medical service before the war consisted of thirteen medical officers. The report of the Minister of Overseas Military Forces of Canada shows that there were 1,451 medical officers overseas at the end of 1918. Of this number only a small proportion had previously been members of the C.A.M.C. Thus the vast majority were taken from civil

practice, and it would seem only fair that these civilian doctors who gave their services at great personal sacrifice should not be punished for their lack of military knowledge, but I regret to say that this is what happened.

One of the most iniquitous things in the medical service was the necessity of eminent medical men being subservient to the administrative heads because the latter controlled promotions, honors and decorations. This war has conclusively demonstrated the fact that the permanent medical organization is not able to cope with the medical and surgical requirements of the army without help from the profession in civil life.

It may be said that surely medical men are above such sordid influences as those referred to above, and I may at once point out that the doctor who leaves his practice and joins a military medical service puts his professional reputation in the hands of those in authority in that organization. They can either make or mar him, and it is a well known fact that it is not necessarily the ablest physician or surgeon who is given the premier position in a military medical organization. In fact one can assert without exaggeration that frequently the reverse is the case.

How then are we to ensure the most efficient medical and surgical service to our wounded? In my opinion, which is shared by the well informed, only by placing in full control of the treatment of the sick and wounded, medical men and surgeons who have proved their superiority in civil life. Such I believe can in no way detract from military efficiency inasmuch as the administrative heads will be left in control of discipline and organization outside of all purely technical affairs.

I had in view when occupied with the task of reorganizing the Canadian Medical Service in London in 1916, the creation of an advisory medical board of consultants drawn from civil life, two consulting surgeons, two consulting physicians and a consulting sanitary officer, who would be charged with the responsibility of the treatment of the sick and wounded, and who would be given authority over the medical and nursing personnel. With the professional side of our medical service in charge of such a board of expert professional men, whose only

thought and responsibility would be the care of the sick and wounded, one could be reasonably assured that the greatest care and discrimination would be exercised in the selection of the medical and surgical staffs of the various hospitals to ensure this end. Such a board would be constantly employed in collecting information as to the best methods to employ in treatment, and when they had reached a conclusion on any subject, such as the primary closure of wounds, or the use of Carrel-Dakin solution, or the necessity for the increase in surgical teams, etc., all they would have to do would be to communicate their decisions to the director of the administrative side of the medical service who possesses the machinery for putting these decisions into immediate effect. *He should have no power to review or veto such decisions.* He would be a member ex officio of the advisory medical board and would be conversant with their work. If the Director-General of Medical Services be (as he usually is) an officer who has not been in close touch with the scientific side of his profession for many years, it would be nothing short of criminal that he be given autocratic powers which would enable him to nullify the decisions of a body of experts.

The American medical service benefiting by the experience of nearly three years of warfare of the British, French and Belgian Medical Services, early arrived at a decision to divorce the purely professional side of their medical service from the administrative side and appointed Dr. Finney, Surgeon to the Johns Hopkins Hospital, and one of the leading surgeons of America, as Director of the General Surgery in France, with the rank of Major-General. They appointed Dr. Thayer, one of the leading physicians of America, as director of the medical side of the service in France, with the rank of Major-General. Dr. Finney surrounded himself with a number of eminent surgical specialists, whom he placed in charge of the various specialties of surgery, notably Dr. Hugh Young in charge of genito-urinary surgery, Dr. Harvey Cushing in charge of neurological surgery. He then appointed a number of consulting surgeons and assistant consulting surgeons for the various armies. This entire organization was responsible to him, and he was the sole director of it. The result of this was that

although America did not get actively into the war until July, 1918, at the Armistice America probably had the most progressive and efficient medical service on the continent. In saying this I do not wish to be understood as in any way deprecating the wonderful work done by the British Medical Service. In fact, many American medical officers acknowledge their deep indebtedness to the British Medical Service for much valuable information, which they made full use of in the organization and development of their own service.

We had no Canadian Consulting Surgeon for our Canadian Hospitals in France during the war. We had no Canadian officer in charge of our Hospitals in France until about a month before the Armistice, when a Canadian Director of Medical Services was appointed. The cumbersome methods and delay, to say nothing of efficiency and waste of money which the absence of a Canadian officer in charge of our hospitals in France involved, is well known to all medical officers who saw service in France.

Although we missed the opportunity of this development during the war that is just over, the subject is one of such paramount importance for our future medical service (because none of us have the Utopian belief that this is the last war) that we should benefit by our experiences as well as our mistakes, and now in times of peace insist upon our army medical service being developed into a sound, strong and efficient organization for the future; and, gentlemen, this can only be done by the profession insisting upon the Government securing the *advice* and *co-operation* of some of the able men who have seen service in this war, all of whom will soon be demobilized.

I should like again to pay a tribute of respect and admiration to the excellent character of the work performed by the medical officers in the C.A.M.C. during these five years of war, at great personal sacrifice.

PUBLIC HEALTH IN CHINA

Charles W. Service, B.A., M.D., of Chengtu, West China.

Promotion of health promises to be the leading ideal of the twentieth century. Social Service, Moral Reform, efforts towards race betterment, and public health work are to the front. The noblest tasks have been contributing to the advancement of man towards physical, intellectual and moral perfection. Millions of dollars are being expended in all civilized lands for the eradication of diseases, and many men are giving themselves as martyrs to science that mankind may have more abundant life. To-day the victories of preventive medicine are outstanding. In all our cities and towns we have health officers and boards with large powers to cope with such an epidemic as Spanish influenza. And a strong and intelligent public opinion sanctions all preventive measures.

While the above is true of the Western world, comparatively nothing is being done for China, the oldest nation of the world, and with one-quarter of the world's population. Surely the millenium has not been found in China where modern sanitation is almost unknown. There is an almost entire absence of hygienic habits among both the higher and the lower classes. All Chinese spit indiscriminately. Close construction of buildings, narrow streets, overcrowding, cesspools, non-disposal of garbage, open latrines, ample means for mosquito and fly breeding, lack of fresh air and sunshine, no attempts at notification, isolation, quarantine and disinfection; the rare practice of vaccination, prevalence of vermin, no knowledge of germs, but general belief that eruptive fevers, etc., are natural evils, make China indescribably insanitary.

There are two large classes of diseases which are very prevalent in China. These are the "operable" and the "preventable." In no country in the world are so many and such large tumors and ulcers. Most of these, if taken early enough, can be completely cured. There is no branch of medical missionary work which appeals more to the Chinese than the fine surgical skill of many missionary surgeons.

The "preventable" diseases cause great havoc among the

Chinese. Ancient Chinese medical books give very scant information on these diseases, and in actual practice the Chinese physicians are helpless. The marvellous progress of sanitary science and the enforcement of public health laws in Europe and America have led to the practical disappearance of such foul and destructive diseases as plague, typhus, relapsing fever, leprosy, smallpox, rabies and malaria. Others like tuberculosis, hook-worm, typhoid, are rapidly disappearing. Means for the prevention and control of even venereal diseases are being adopted.

But in China every year, epidemics of plague and of other preventable diseases hurry multitudes to early graves and to awful poverty. In China we have the malaria parasite in all its forms. That great devitalizing agency, hook-worm disease, which entails much economic loss and reduces countless millions to lazy sluggards, is widespread. In some parts of China more than half the people are affected. Tuberculosis is rampant, with a mortality of about two millions per year. Cholera, dysentery, and infantile diarrhea are very destructive of life. In addition to hook-worm disease, other parasitic intestinal infections are rife. It is estimated that from thirty-five to fifty per cent. of all infants born die of lock-jaw within two weeks of birth. Blindness is one of the most common sights in China, and yet most of it is preventable. Vermin-carried diseases are everywhere, and these do not spare missionary physicians, seven of whom died two years ago from such causes.

Laboratories of hygiene, bacteriology, pathology, etc., so essential in preventive medicine, are absolutely wanting. On the contrary, we find quacks and humbugs practising medicine indiscriminately, and turning out patent medicines without restraint by public health laws.

Yet, speaking generally, even the most educated Chinese still remain in apathy, not realizing the gravity of the situation and the importance of organized effort. The Chinese are most particular during illness, as seen in the number of physicians called in for one single case. Yet they are not the least concerned about the preventive measures against the spread of disease. It is ignorance that breeds this indifference. Even the foundations of hygiene are not known.

Preventable diseases are social problems beyond the control of the individual. This means that the remedy is not alone the treatment of the patient by the individual doctor, but rather the broad treatment of the entire social organism by all the constructive forces available. Therefore public health education is the keystone. Without it social conditions cannot be improved, nor can many of the communicable diseases ultimately be stamped out. The rate at which diseases can be wiped out is determined by the amount of regulation which the people will observe. There has to be a specific amount of legislation. But restriction of personal liberty must be understood and supported by the public. It therefore becomes imperative to educate and inform on the modern discoveries regarding disease and to inculcate the idea of the intrinsic as well as the economic, value of human life. The people themselves must be led to know that they are the beneficiaries, both in the saving of lives and of money.

But the difficulty comes in attempting to realize this ideal. A bettering of living conditions, which in China are beyond description, and the lowering of the death rate, are very difficult of accomplishment, because disease, poverty and ignorance, with resultant indifference, are undoubtedly in most aggravated forms. The death rate is at least forty per thousand (compare fourteen in the United States). The average per capita wealth is not more than one hundred dollars. The great masses of China live on the borderland of starvation all the time. Probably not more than four per cent. of children of school age are actually in school. These surely are handicaps in popularizing public health knowledge.

Yet some day we hope to see China healthy—politically, socially, morally, intellectually, physically—without putrefying bodies, ill-smelling sewers, dark and insanitary dwellings, sunken-chested, round-shouldered scholars, mis-shapen feet, unsightly tumors, dirty ulcers, infected eyes, plagues, epidemics and diseases of many kinds. China has some strong links in her chain of national strength such as favorable location, natural resources, frugality, industry and general intelligence of her people, and filial piety. But another important link is lacking, viz., public health. Therefore the people must be

informed and gradually led to readjust their social organism to correspond with their improved knowledge. The responsibility for these conditions as well as the power for improving them, lies with the people and their rulers. The medical profession can and should furnish the technical information. Physicians can point out the way and can lead in the fight; but public support is necessary, to secure which the people must understand what is needed and why it is necessary.

The missionary medical profession, despite its paucity of numbers, is one of the most potent agencies for public health education, although it is overburdened with other professional duties. Its influence is being increasingly felt throughout China. It can do much to rouse a sanitary conscience. It already largely has the confidence of the Chinese public. Thus it has a greater responsibility to the Chinese than the mere establishment of hospitals and medical colleges. Medical men must be ready and free to preach disease prevention as well as treat ailments. Missionary medical colleges must place public health in the forefront, so that graduates may be more than mere practitioners. Students must be encouraged to "talk shop" on disease prevention. Popular books and articles must be published. Social leagues of men and women must be organized by our doctors and others. These leagues would serve to teach the poor practical methods of self-protection, and would enable the leisurely class of men and women to do unselfish work for others, and thus cultivate patriotism and altruism. Public health campaigns, exhibits and literature must be widely used. All these methods are being employed, but only a beginning has been made.

Public health education and social service are fundamental and will accomplish several splendid results: (1) The unhealthy conditions of life in overcrowded Chinese cities will be changed and the dangers of epidemics and plagues will be lessened. (2) Enlightenment will cause discontent with quackery and with the ignorance of the Chinese doctor. (3) It will eventually ensure the establishment by the Chinese themselves of medical schools. (4) It enhances the standing of the missionary doctor among the Chinese. (5) It furnishes definite points of contact with the better classes, by inviting

the co-operation of the gentry, merchants, educators and other leading personages. (6) It wins friends for and increases the influence of, the hospitals, the doctors and the Christian cause, by revealing Christianity as having an all-round interest in mankind. (7) It helps to Christianize and vitalize the small but growing western-trained medical profession in China, which already has many Christian men, and is kindly affected towards Christianity. Already there exists a Joint Council on Public Health Education, including representatives from the China Medical Missionary Association, the Y.M.C.A. of China and the National Medical Association of China, whose president, Dr. Wu, a foreign-trained doctor of great ability and a Christian, is chairman of the Joint Council. This Joint Council is a bond which should be strengthened.

Why should the Christian Church and its great ally, Western medical science, engage in this work? There is an epidemiological value in medical missions. In March, 1918, in a Peking paper, Dr. S. P. Chen, of the Chinese Plague Preventive Service, described the serious difficulties encountered by the department in battling with the recent epidemic of pneumonic plague in North China. He ascribes these difficulties mainly "to the ignorance on the part of the people of modern medical methods, due to the complete absence of missionary or other medical institutions in the districts affected by the epidemic. Their existence would have paved the way for the attack by giving the people an insight into the advantages of Western medical science over Chinese medicine, and by thus creating a more favorable atmosphere for modern medical methods to be applied."

Furthermore, although medical missions are doing much to treat China's sick, yet there are no agencies adequately engaged in teaching prevention. Now the health of China is coming to be more and more the health of the world. Very soon every nation will try to develop extensive commercial relations with China. She will become a real neighbor to other nations. Her diseases will be theirs. Her health will mean more business, more buying power, greater ability to develop her natural resources, and greater contributions in material and spiritual resources of the world.

Society Proceedings

ACADEMY OF MEDICINE

Welcome Home Dinner.

A welcome home was extended by the Academy of Medicine of Toronto on Tuesday evening, September 30th, to those of its fellows who have returned from service overseas, at a banquet given at the King Edward Hotel. The Academy sent one hundred and fifty of its members to the war, and a large number of them were present to enjoy the hospitality of their confreres last evening.

The toast to the overseas fellows was proposed jointly by President Sir Robert Falconer, of the University of Toronto, and Colonel H. C. Bickford, D.S.O., both of whom paid high tribute to the sacrifice and service of the Canadian Medical Corps. The latter stated that he had seen the work of the corps, both on the Western Front and in Siberia, and could not speak too warmly of it.

Major-General Fotheringham, D.G.M.S. at Ottawa, illustrated the efficiency of the Canadian medical service by quoting the fact that since 1914 its hospitals had admitted 750,000 cases and had recorded a death rate among them of only 2.9 per cent. The excellency of the field work of the corps, he said, was demonstrated by the fact that only five per cent. of fatalities in the Canadian army were attributed to disease.

Among other speakers were Colonel J. A. Roberts, of the 4th Canadian General Hospital; Colonel R. D. Rudolf, of the 2nd C.G.H.; Colonel Walter McKeown, Colonel Herbert Bruce, and Colonel C. L. Starr. Dr. E. E. King, the President of the Academy, acted as toastmaster.

ANNUAL MEETING OF LEEDS AND GRENVILLE MEDICAL ASSOCIATION

The annual meeting of Leeds and Grenville Medical Association was held in the Town Hall at Prescott, on September 19, between forty and fifty members being present from all parts of the counties, Gananoque, Brockville, Kemptville, Lyn, Spencerville and other points being represented. After the meeting a banquet was held. Officers were re-elected for the ensuing year as follows: President, Dr. Storey, Kemptville; Vice-President, Dr. C. H. Bird, Gananoque; Secretary-Treasurer, Dr. Gordon, Kemptville. A paper was read by Dr. D. T. Smith, Ottawa, and short addresses were delivered by Dr. McCurdy of Truro, N.S.; Dr. W. Norman Gilmour, Brockville (these two gentlemen gave a short account of their work overseas); Dr. J. C. Mitchell, Brockville, Dr. G. D. Gordon, of Kemptville, and Dr. H. A. Clare, Medical Director of the Ontario Hospital, Toronto.

UNIVERSITY OF TORONTO'S NEW CHAIR IN MEDICINE

Through the munificence of Sir John and Lady Eaton, who have given half a million dollars to equip a new chair of medicine at the University of Toronto, that institution will have opportunities for medical development surpassed by few universities on the continent, announced Sir Robert Falconer in Convocation Hall, on September 30th, in his address of welcome to incoming students. Dr. Duncan Graham, one of the university's own graduates, Sir Robert announced, will fill the new chair. Sir John's gift is on the understanding that a professor shall be appointed who will have a free hand and will devote his time to the organization and direction of the department.

"The purposes of this gift," continued the president, "could not be carried out by the university alone without the co-operation of the Trustees of the Toronto General Hospital, who have acceded to the university's request in this matter. Formerly there were three medical services in the hospital, and

cases were provided in rotation to each service, an arrangement which did not allow them to be grouped according to diseases, so that they might receive investigation and treatment in a group. Under the new arrangement there will be but one service in the Toronto General Hospital, which will be directed by the Professor of Medicine.

"It is essential that for the purpose of co-ordination the occupant of the chair should have a free hand, both in the university and in the hospital. Instead of patients being sent in routine to different services, they will be selected according to their diseases and treated by physicians who devote especial attention to these cases, the patient getting completer treatment and the student much more thorough and co-ordinated instruction in the specific diseases.

"The professor of medicine, having, in fulfilment of the terms of the gift, been given a free hand at organization and teaching within the university and within the hospital, will devote his whole attention to placing the medical education of this university and the treatment of the sick in the hospital wards on the highest possible plane."

CHANGES IN TORONTO GENERAL HOSPITAL STAFF

In connection with changes to be made in the staff at the Toronto General Hospital the names of a number of medical men have been unofficially announced as taking charge of the reorganization and work of various departments.

Dr. John Oille will have charge of the heart clinic; Dr. F. W. Rolph, the gastro-intestinal department; Dr. Goldwin Gowland, nervous diseases; Dr. George Young and Dr. George Strathy, the general medical clinic. Dr. Rudolf remains in charge of therapeutics, Dr. Harold Parsons of tuberculosis, and Dr. C. K. Clarke as head of the psychiatric department. Dr. William Goldie will have charge of the indoor patients' ward. In the surgical departments no appointments have been made yet.

THE ONTARIO ASSOCIATION FOR THE CARE OF THE FEEBLE MINDED

At the annual meeting of the Ontario Association for the Care of the Feeble Minded, the following officers were elected for the ensuing year: Honorary President, Dr. C. K. Clarke, Toronto; President, T. H. Wills, Hamilton; First Vice-President, Mrs. A. M. Huestis, Toronto; Second Vice-President, Sheriff D. M. Cameron, London; third Vice-President, Dr. J. H. Putnam, Ottawa; Fourth Vice-President, Judge Hardy, Brantford; Secretary-Treasurer, Dr. O. C. J. Withrow, Toronto.

To this was added a strong executive committee, to the number of twenty-six.

A TIMELY WARNING

Physicians in Quebec are giving warning of the danger of germs of communicable diseases being brought over from Europe in the baggage of the returned soldiers. Local health authorities in Canadian communities should not let this go unheeded.

Dr. J. G. Page, Immigration Health Inspector at the Harbor of Quebec, says the press should give the greatest publicity to outbreaks of smallpox, and other contagious diseases, so that the public can be aroused to the danger and help in the cause of prevention by encouraging public vaccination, and quarantine regulations.

Recently Dr. P. Martineau, Superintendent of the Quarantine Station, forty miles below Quebec, ordered one of the large incoming troopships detained longer than expected, and sent a special boat to Quebec to bring a large quantity of vaccine.

Personals

Major Dr. Harley Smith, returned last month after spending nearly four years overseas and has opened his office at 143 College Street.

Dr. George Smith, 244 Bloor Street West, wishes to announce that he is limiting his practice to the diseases of children and diseases due to protein sensitization (hay fever, asthma, eczema).

Dr. J. Harris McPhedran, 155 Bloor Street East, wishes to announce to the medical profession that having returned from overseas he will confine himself to the practice of internal medicine.

We take this opportunity of expressing to our esteemed collaborator, Dr. Alexander Primrose, very sincere sympathy on his recent bereavement. Mrs. Primrose had been an invalid for about two years. Her death took place on October 2nd at her house, 50 Forest Hill Road.

Several new associate Coroners have been appointed by the Government. They are: G. R. Miller, of Stayner, for Simcoe County; J. C. Wilson, of London, for Middlesex County; W. G. Hamilton, of Westport, for Leeds and Grenville Counties; Alexander McLeod, of Wroxeter, for Huron County; V. E. Cartwright, of Pickering Post Office, for Ontario County.

Brigadier-General A. E. Ross has joined the Hearst Administration as Minister without Portfolio. General Ross is a physician who rendered distinguished service with the C.A.M.C. in France. He formerly sat in the Legislature for Kingston, Ont. It is expected that if Sir William Hearst is

returned on October 20th (we go to press prior to the date) he will subdivide the Provincial Secretary's Department, and place General Ross in charge of public health, and charitable and correctional institutions.

MEDICAL MEN TO ACT UNDER PATENT MEDICINE ACT

To comply with the requirements of the new amendment of the Proprietary or Patent Medicine Act, an order-in-Council was passed on October 10th on the advice of the Deputy Minister of Health, appointing the following members of the Proprietary Medicine Board:

Dr. Alexander Blackader, professor of pharmacology, McGill University, Montreal; Dr. R. D. Rudolf, professor of therapeutics, University of Toronto; Dr. A. McGill, chief analyst, Food and Drug Laboratories, Department of Health, Ottawa; Dr. E. W. J. Lecaurs, professor of pharmacy and vice-president of the Laval School of Pharmacy, Montreal; Dr. Chas. F. Heebner, dean of the College of Pharmacy, Toronto.

This board has been formed to advise the Federal Department of Health on questions arising in regard to patent medicines, etc., as affected by this amendment to the Proprietary or Patent Medicine Act.

Obituary

DR. KAYLER DEAD

Dr. William B. Kayler, who died on September 19th, at his residence, 183 Annette Street, West Toronto, had practised medicine in Toronto for eighteen years. He was a graduate of Queen's University.

The Physician's Library

War Surgery of the Face. A Treatise on Plastic Restoration After Facial Injury. By John B. Roberts, A.M., M.D., F.A.C.S., Professor of Surgery in the University of Pennsylvania; Graduate School of Medicine. Illustrated by 256 figures. New York: William Wood & Co. 1919.

It is most fitting that to the Dean of American Surgery, as regards injuries and diseases of the face, came from the office of the Surgeon-General the suggestions that led to the preparation of this good book. Dr. Roberts' previous writings on facial surgery gave us warrant for expecting a work which would bring thoroughly up to date the advances made during the great war, and in this we are not disappointed. The principles of surgical science underlie both the traumatisms of war and those due to industrial accident, and no one appreciates this better than the veteran Philadelphia surgeon. Now that "the war drum throbs no longer and the battle flags are furled," it is in the treatment of the injuries incidental to industrial life that this book gives promise of being most signally helpful. The first 62 pages are given up to a discussion of the superficial and deep anatomy of the parts involved. While such knowledge is absolutely essential and while it is given with clearness and precision it is in no degree better than the sections devoted to this region in our standard works on anatomy. In the judgment of the reviewer it might with advantage have been condensed or omitted. Following this comes the consideration of the pathology and treatment of war wounds of the face and then the reconstructive treatment of war injuries of the face. Both sections are replete with interest, and the manner in which they are presented is worthy of unstinted praise. The author's vast experience, his ripe judgment and his well recognized skill

as an operator has enabled him to test out for us the newer procedures and to compare them with methods by which measurable success has been, in the past, attained. The publishers have done their part well, giving us a volume which is a pleasure to read.

Catechism Series. Operative Surgery. By C. R. Whittaker, F.R.C.S.E., F.R.S.E. (late Capt. R.A.M.C.) Second edition, Part 1. *Chemistry—Inorganic.* Second edition, Part 1. *Anatomy—the Bones and Joints.* Third edition, Part VI. Edinburgh: E. & S. Livingstone, 17 Taviot Place.

In these little pamphlets the several subjects are dealt with in a terse and lucid manner. They are not intended to take the place of text-books on these subjects, but to serve as an aid to the student in crystallizing and systematizing his ideas. The books are written in the form of a catechism with the questions and answers arranged to cover the field in an orderly fashion. The addition of an index for each volume would be a very valuable improvement.

Reconstruction Therapy. By William R. Dunton, Jr., M.D., Assistant Physician at Sheppard and Enoch Pratt Hospital, Towson, M.D.; Instructor in Psychiatry, Johns Hopkins University. 12mo. of 236 pages, 30 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, $1.50 net. Canadian Agents: The J. F. Hartz & Co., Ltd., Toronto.

For those who have come into contact with the war cripples, and for others interested in the betterment of human beings under par, nothing can be of greater interest than the problems of reconstruction. In former years this problem did not present itself to the public as a very vital one, but recently it has been forced upon them in a manner which cannot be disregarded.

In this book, Dr. Dunton discusses the historical aspect of reconstruction therapy, and its development to the present time. He also shows that we are just realizing the actual necessity for it, and points out that the enthusiasm initiated by the present war problems must be guided into proper channels to obtain the most permanent benefit.

In a very comprehensive way, and with a praiseworthy attention to detail, he sums up the duties and qualifications of an occupation director; a position strewn with many pitfalls to the unwary.

In several chapters he outlines a very acceptable plan for the occupation of patients of various types, both from a mental and physical point of view. The chapters on prosthetic appliances are descriptive and illustrative, rather than technical, and he is to be congratulated on having shown what can be accomplished by double amputation cases. As every one knows who has had to deal with these cases, the treatment is merely begun when the appliances have been furnished.

After that it is a matter of persistent and sometimes very discouraging effort to advance the patient to a point where he is able, and I may say willing, to carry out work which will enable him to become independent of outside assistance. The mental or rather psychical treatment is no small part of the medical man's task in the therapy incidental to the crippled man.

That Dr. Dunton should enter into a discussion of the comparative merits of artificial arms seems rather a pity, as it is quite generally admitted that a universally efficient arm has yet to be invented. Different types of artificial arms are suitable for different men, not so much for the actual deformity as for the occupation and individual ability and wish to use the mechanical apparatus. The problem of artificial legs is much simpler, though here again the case for the slip-socket type in below the knee amputations has been given perhaps a little more than necessary prominence.

In the chapter on physical education, various sorts of games and suitable exercises are enumerated, and the author very correctly points out that those games which arouse the

interest of the patient are of far greater benefit than formal exercises.

In his conclusions, Dr. Dunton draws attention to a point which is of primary importance in reconstruction work, and that is the emotional reaction of the patient. It is imperative that this be taken into account; otherwise the scheme for the patient's betterment may be futile. Among patients one finds all types of intellectual and mechanical tastes, and it rests with the teacher or occupation director first to determine the potential capabilities of his patient, and then to develop him along these lines.

The book is a pleasing and successful effort to epitomize not only the author's work, but the current literature on the subject; a good bibliography of which has been added.

The Practical Medicine Series. Comprising eight volumes on the year's progress in Medicine and Surgery, under the general editorial charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern University Medical School. Vol. I. General Medicine, edited by Frank Billings, M.S., M.D. Part I. Assisted by Burrell O. Raulston, A.B., M.D. Part II. Assisted by Bernard Fantus, M.S., M.D. Series 1919. The Year-book Publishers, 304 South Dearborn St., Chicago.

This volume discusses the latest points on infectious diseases, diseases of the heart, blood vessels, lungs, blood and blood making organs, ductless glands, metabolism, kidneys, liver and gall-bladder, gastro-intestinal tract. The contributions are largely culled from periodicals and synopsized. A summary of "Diagnosis and Treatment of Dysentery," published in the *Lancet* from the pen of the new professor of medicine in the University of Toronto, will be of academic interest, at least to the profession here. This collection of the latest theories and practice in medicine should be welcomed by the general practitioner who wishes to keep in touch with the most recent advances.

The Elementary Nervous System. By G. H. Parker, Sc.D., Professor of Zoology, Harvard University. 53 illustrations. Philadelphia and London: J. B. Lippincott Co. $2.50 net.

From the study of the nervous systems of the most elementary life up to the lower forms of animals, the author lays before the reader a fund of information and inference that should be taken advantage of by all students of medicine as well as all interested in Biology and Zoology. All through the book the physiology and histology of the receptor-effector system is keenly developed and discussed, the bibliography is large and the book is full of inference and food for thought for any one interested in the central and peripheral nervous systems in plant and animal life.

Hughes' Nerves of the Human Body, with plates. By Chas. R. Whittaker, F.R.C.S. (Ed.), F.R.S.E., etc., Senior Demonstrator of Anatomy, Surgeons' Hall, Edinburgh; Lecturer on Biology, New School of Medicine, Edinburgh. Second edition, revised and enlarged. Edinburgh: E. & S. Livingstone, 17 Teviot Place. 1918. Price 3s. 6d. net.

A splendid little book with good cuts and diagrams and a fund of information in concrete form. It should be the constant companion of all students and medical practitioners whether doing medicine or surgery, for in its seventy-three pages are numerous points to refresh the memory and to aid in the diagnosis and treatment of nervous diseases.

Canada's Sons and Great Britain in the World War. A complete and authentic history of the commanding part played by Canada and the British Empire in the world's greatest war by Col. George G. Nasmith, C.M.G., Canadian Expeditionary Force, author of "On the Fringe of the Great Fight." With an introduction by Gen. Sir Arthur Currie, K.C.B., K.C.M.G., Commander of the Canadian Army

Corps. Illustrated with reproductions from the official photographs of the Canadian and British Governments. The John C. Winston Co., Limited, Toronto.

It seems but a short time ago that we had the great pleasure of reading the author's "On the Fringe of the Great Fight." "Canada's Sons and Great Britain in the World War" is a worthy successor. It is intensely interesting, from the splendid introduction by General Sir Arthur W. Currie to the last chapter, "The Year of Victory." The book depicts the frightful struggle in which the whole world was engaged for almost five years. It might too truthfully be called "The War History of the Canadian Nation Since 1914," and Colonel Nasmith has furnished us with a history of what our grand Canada did in bringing the Bloody Hun to his knees. The book is a Canadian product, written by a Canadian, of Canadians, and for Canadians, and we bespeak for it a very large sale.

Clinical Microscopy and Chemistry. By F. A. McJunkin, M.A., M.D., Professor of Pathology in the Marquette University School of Medicine; formerly an Assistant in the Pathological Laboratory of the Boston City Hospital. Illustrated. Philadelphia and London: The W. B. Saunders Company. Canadian Agents, The J. F. Hartz Co., Limited, Toronto. 1919. Price, $3.50 net.

It is the object of this work to cover the subject of clinical medicine from the laboratory side with special reference to the chemical, bacteriologic, serologic and pathologic methods, together with short clinical descriptions. The various blood diseases are described with the differential counts, stains, methods of staining and good plates of corpuscles and protozoa. There is a good chapter on serology, including the Widal reaction, agglutinating test for transfusion, opsonic index, cytolysis in vitrio, ferments and anti-ferments, identification of human blood-stains, Wassermann reaction and bacteriologic examination of blood sputum, serous fluids, exudatis and cerebro-spinal fluid. Gastric contents, feces, urine and renal insufficiency tests

are fully described. There is a closing chapter on histologic and autopsy technic. The association of clinical medicine with the laboratory methods makes this work especially valuable.

A Manual of Exercises for the Correction of Speech Disorders. By May Kirk Scripture, B.A., and Eugene Jackson, B.A. Illustrated. Philadelphia: F. A. Davis Co., publishers. English Depot: Stanley Phillips, London. 1919.

This publication is a manual of exercises, these being the result of thorough experimentation with both private and clinical dispensary patients subject to speech defects. The exercises are simple, graded, well classified and suitable for pupils of practically every age. Throughout the book minute instructions are given as to the carrying out properly of each exercise. For those undertaking the correction of speech defects this volume is recommended as being one of undoubted value.

The International Medical Annual. A Year Book of Treatment and Practitioner's Index. Associate editors: Carey F. Coombs, M.D., F.R.C.P. (Medicine); A. Rendle Short, M.D., B.S., F.R.C.S. (Surgery). 1919. Thirty-seventh year. New York: William Wood & Company. Price $5.

Among the contributors to this volume for 1919 we find such names as Drs. Francis J. Charteris of the University of Glasgow; W. E. Fothergill, Manchester Royal Infirmary; John S. Fraser, Royal Infirmary, Edinburgh; G. W. Goodale, London, England; Robert Hutchison, London Hospital; Arthur Lattam, St. George's Hospital, London; Joseph Priestley, Royal Sanitary Institute; and P. Watson Williams, Bristol Royal Infirmary. This volume is indeed a *multum in parvo* and contains a wealth of knowledge from the pens of many of the best known physicians and surgeons in the old land. No member of the profession can make a mistake in purchasing a copy.

Correspondence

The Editor,
The Canadian Journal of Medicine and Surgery,
Toronto.

Dear Sirs: In the September number of your journal, under the heading "Society Proceedings," I notice an article referring to the meeting of the Canadian Medical Association, held in Quebec in June of this year. In this article, which is on the subject of the resolution brought forward by Col. Herbert A. Bruce, of Toronto, you make certain statements which I feel called upon to correct. You state, for instance, that "an attempt was made by the Executive to prevent this resolution and two others coming before the General Association, etc." As a matter of fact the very opposite is the case. The Executive Council, while reporting unfavorably on this resolution, sent it forward to the General Session in order that the whole Association should decide.

I may also state that the Executive Council did not shelve any resolution. Every resolution properly presented with mover and seconder was passed along to the General Session of the Association, with or without the approval of the Council. In the latter case, it was the desire of the Council that the General Session should decide the matter.

I regret very much that your journal should have published any such garbled statement on the action of the Executive Council at the Quebec meeting, and I hope you will give this letter as prominent a position in your next issue as that occupied by the article to which I am taking exception.

Yours very truly,
J. W. Scane,
Acting Sec.-Treas., Canadian Medical Association.

The article complained of in the above letter was written by our special correspondent, who attended the meeting and who based it upon a statement made to him by a member of the Executive Council.

He was told that at a meeting of the Executive Council it was decided that "no resolution of a political character should be passed on to the general session," and as Colonel Bruce's resolution, and one by Colonel F. W. Marlow and another by Major F. N. G. Starr, were all deemed to be of this character, it was assumed that they would not be sent on to the general session, and apparently this would have been the case had it not been for the fact that the Executive Council's resolution, when presented to the general session, was defeated by the casting vote of the chairman—the President of the Canadian Medical Association.

Colonel Bruce spoke strongly against this action of the Executive Council, and urged the impropriety of allowing them to decide as to whether a resolution was of a "political" character or not, taking the stand that this should be decided by the Association.

Upon the defeat of the Executive Council's resolution mentioned above, Colonel Bruce requested that his resolution be brought before the meeting, when it was passed, after the deletion of an important clause which was thought to be critical of the work of the C.A.M.C.

At the recent meeting of the Canadian Medical Association, held in Quebec, on June 25th to June 28th last, the following resolution was moved by Colonel Herbert A. Bruce, of Toronto, and seconded by Colonel Geo. E. Armstrong, Montreal, and unanimously adopted:

That the Canadian Medical Association takes this opportunity, the first after the cessation of hostilities, to record its deep appreciation of the sacrifice made by our profession in Canada during the long war which has just ceased. We are proud to think that no class in Canada has done more to show its patriotic and sound citizenship than the medical men. It is with deep feeling we offer our sympathy to the relatives of those medical men who have so nobly given up their lives for their country, and to those who have sustained wounds and loss or deterioration of health as the result of war service. We feel that the medical officers, nursing sisters and the rank and

file of the Canadian Army Medical Service by their patriotic and self-sacrificing devotion to duty have contributed in a large measure to the winning of the war, and have reflected great credit on Canada. It is evident that even though the war is now over, a permanent army medical organization must be maintained, and the following suggestions are offered in order that we may profit by the experiences gained in this war:

(1) That a course be given in each Canadian Medical College on such subjects as medical history of the war, military sanitation, military medical organization, etc.

(2) That a research fellowship be established by the Militia Department in each Medical College in Canada for graduates who show special aptitude for such work, and that provision be made for their accommodation in the National Health Laboratory, which, we understand, is to be established in the Federal Department of Public Health.

(3) We would suggest that the rate of pay of the medical men of the permanent medical army service be put on a par with the R.A.M.C., in order to attract the better class of medical men to the Canadian Medical Service.

(4) That these and other suggestions for the improvement of the Canadian Army Medical Service be referred to a committee, constituted as follows: The Presidents of the Canadian Medical Association and each Provincial Medical Association; one member from the Faculty of each Medical College in Canada; and the following officers:

Brigadier-General A. E. Ross, C.B., C.M.G., C.A.M.C., Kingston.
Col. J. D. Courtney, Ottawa.
Col. C. Peters, D.S.O., Montreal.
Lieut.-Col. F. H. Mewburn, O.B.E., Calgary.
Lieut.-Col. F. McTavish, Vancouver.
Lieut.-Col. S. W. Prowse, Winnipeg.
Lieut.-Col. J. Hayes, D.S.O., Halifax.
Lieut.-Col. Charles Hunter, Winnipeg.
Lieut.-Col. Munroe, Saskatoon.
Lieut.-Col. Clarence L. Starr, Toronto.
Major Harry Morrell, Quebec.

And the mover and seconder of the resolution: and that this committee be given power to add to its numbers.

That a copy of this resolution and a report of the committee be forwarded to the Prime Minister of Canada."

The Executive of the Ontario Medical Association in session at Toronto, June 20th, 1919, resolved as follows:

"(1) In view of the apparent widespread discontent and dissatisfaction amongst returned, discharged and pensioned soldiers as to the administration and carrying out of medical services provided for them, it seems urgent that some action should be taken by the Canadian Medical Association to bring this matter to the attention of the Government with a view to having a thorough and complete investigation and if necessary an effective readjustment.

"(2) That this resolution be presented to the Canadian Medical Association at its annual meeting in Quebec by the President of the Ontario Medical Association."

The above resolution was presented by the President of the Ontario Medical Association, Colonel F. W. Marlow, at a meeting of the Executive Council of the Canadian Medical Association during the annual meeting of the Association at Quebec, but, by a majority vote in Council it was decided that it had a "political tinge," and that it should not be presented at the general business meeting of the Association with the sanction of the Council. Its subsequent disposition is unknown to the President of the Ontario Medical Association, for although a resolution brought forward by the Council to the general meeting, to the effect that no resolution of a "political tinge" would be allowed to be introduced at the general meeting was defeated after considerable discussion by the casting vote of the President of the Canadian Medical Association, the President of the Ontario Medical Association was unable to remain until the end of the business session on account of having to hasten away to get the boat for Montreal, and so could not present his resolution personally, and he was not subsequently informed as to whether the secretary brought it to the attention of the meeting or not.

Major F. N. G. Starr does not know the fate of his resolution.—[Editor.]

Publisher's Department

SALICYLATES BY INUNCTION IN RHEUMATISM

In rheumatism and allied conditions there is a perversion of the normal body chemistry, which under effective elimination of auto-toxins and moderate stimulation of sluggish functions, generally rights itself, particularly when reasonable care is given to regulation of the diet, both as to kind and quantity of foods allowed.

For the associated pain of rheumatism, we have in sodium salicylate and acetyl salicylic acid drugs of tried and proven worth, which it would not be easy to replace. But sodii salicylas is not always tolerated by the stomach, soluble and readily absorbable though it be, and there are grave cardiac cases where even acetyl salicylic acid must be used sparingly. When taken into the organism, sodium salicylate is believed to cause the elimination of the excess of uric acid circulating in the blood and other body fluids or deposited locally, thereby relieving the economy of a principal factor in its state of derangement and permitting of gradual improvement in the patient's condition. Methyl salicylate when applied in proper dilution to the skin, is absorbed, taken up by the blood, and combining with its sodium salts, converted into sodium salicylate. So generally satisfactory is this method of administration that many physicians employ it almost to the exclusion of salicylates by mouth. It is not to be denied that some benefit obtains in the massage by which the inunction is accomplished.

Several vehicles have been employed for the conveyance of methyl salicylate to be given via the skin: physicians are familiar with these and rightly esteem them.

Possibly the most effective is Iodex, because of the unique absorbability and deep penetrative power of its base, and the unquestionable advantage of the iodine association obtained.

Iodex ē Methyl Salicyl. has proved in clinical use to be a superior local analgesic and anti-rheumatic.

One-half drachm is smeared on the skin and rubbed with the hand until its black color completely disappears. This should be repeated three or four times a day. The inunction may be made at or near the seat of pain or at any point that is vascular and well supplied with absorbent tissue.

An alternative method of employing this absorptive and analgesic agent in cases where there is much tenderness is to gently smear it upon the affected part and cover with lint and oiled silk.

Methyl Salicylate is contra-indicated where the skin is broken and upon mucous surfaces generally as it may cause intense irritation in such loci.

ONE OF CANADA'S OLD-ESTABLISHED MORTGAGE CORPORATIONS

THE particular attention of the medical profession is called to the record and reputation of one of Canada's old-established and conservatively-managed mortgage corporations. The Canada Permanent Mortgage Corporation is the oldest, largest and strongest of these corporations. It was established in 1855, and has a record of sixty-four years unrivalled in the history of similar institutions. In addition to the carefully selected securities in which their monies are invested, Canada Permanent debenture-holders have the further security of eleven and one-half million dollars of shareholders' funds. Any physician desiring a thoroughly comfortable investment, which will relieve his mind from all anxiety as to its safety, can find nothing more desirable than the debentures of the Canada Permanent Mortgage Corporation. They combine the inherent elements of safety for which mortgage corporation debentures are noted, with the reputation and solidarity of the institution, which, in the early seventies of last century was the pioneer in introducing this form of investment, and has been largely responsible for creating the enviable record attained by Canadian Mortgages Corporation Debentures.

DAYLIGHT SAVING

A FACT which, while of small importance to some of the public, is of undoubted importance to the medical profession in connection with this controversy, is that the hours of darkness during which a member of the medical profession finds it necessary to use his automobile are considerably lengthened.

Now that the short days are with us and the clock will be returned to its normal position very shortly, the hours during which the electric light on an automobile must be in service will increase rapidly.

Special care should therefore be taken that your batteries are in good condition and are kept in good condition.

We would refer you for expert battery service work to the Chas. E. Goad Engineering Company, Limited, 105 Bond Street, Toronto, who are the Canadian representatives for the well known electric storage battery known under the trade name of "Exide," with whom we have made an arrangement which should prove mutually satisfactory both to them and to the members of the medical profession.

See their advertisement on page IV of this issue.

IN SEASON

THE old saying that "every dog has its day" can be medically transposed to read "every season has its distinctive disease." Autumn is considered the time for typhoid, so that when a patient complains of headache and malaise which has continued for a day or so, with perhaps some abdominal discomfort, accompanied with or without diarrhea, he should be put to bed for observation and certain prophylactic measures adopted.

The first thing to do is to thoroughly clean-e the bowel, and for this "any old thing" will not do. Medical authorities agree that this must be done in a thorough manner, so as to relieve the bowel of any matter that would aid in the growth of the bacteria and cause, as well, fermentation. It is neces-

sary to remove all toxins present as far as possible; not only those in the intestines, but also to promote their elimination from the blood. It must be borne in mind, however, that the agent used will not cause undue irritation nor delete the system to an extreme weakened condition..

Castor oil alone meets each of these requirements and is considered "the first aid in prophylaxis" for typhoid cases.

Later on in typhoid, Bass and others have found that the continued use of castor oil was fully equal if not superior to intestinal antiseptics. It reduces the fever, prevents tympanites, as well as removes the odor from the stools, doses given every twelve hours giving the best results.

The objectionable features inherent in castor oil will not be found in Laxol and consequently it can be used in every case without the least repugnance to the patient. In prescribing Laxol, the doctor specifies a superlative product of Ricini communis, medicinally superior to "any old kind of castor oil."

A RELIABLE FIRM OF TORONTO BROKERS

A short time ago when a number of physicians were together, an informal discussion took place on the subject of investments. It was generally felt that some method of protection should be devised whereby medical practitioners might be safeguarded, as far as possible in their selection of securities. Doctors have frequently been unfortunate in their investments through the absence of the necessary investigations to reasonably ensure safety. Among the many excellent Investment Houses in Canada one of the reliable ones is Messrs. Bongard, Ryerson & Co., 85 Bay Street, Toronto. They have the usual brokers' facilities for prosecuting enquiries and we are satisfied that they will give their best efforts to all enquiries made.

AN IDEAL RESORT FOR CONVALESCENT PATIENTS

Physicians have frequent opportunities of referring those convalescing from illness to a resort where they can quickly recover their old-time vigor and enjoy an almost ideal climate, 2,500 feet above sea level. Such a resort is Virginia Hot Springs, just one night out of New York. The management have spent a huge sum of money on this choice spot in "Old Virginny," and are anxious that the Canadian medical profession should continue to refer cases there, as they have done in years gone by. The Homestead Hotel is one of the handsomest houses in America. It is built of solid brick, containing 500 guest rooms, with many parlor suites and 300 private baths. It is spacious, dignified, quiet and restful, with magnificent mountain views on every side. It is no exaggeration to say that Hot Springs means the Homestead Hotel. The Company owns 5,000 acres surrounding the hotel, so that physicians can understand that their patients have every opportunity of enjoying outdoor life and regaining thereby their normal strength.

The dominant factor making Hot Springs world-famous is the cure in which the climate as well as the water assist. The waters are conducted by gravity to the bathhouse and distributed fresh from the ground to the bathing apartments on different floors without loss of heat or its increase by artificial means, and fully charged with all their gases and other health-giving qualities. At none of the celebrated places in Europe, and at no other springs in America, is the temperature prescribed for hot baths that at which the water actually emerges from the earth in the natural springs.

The springs are beneficial, not only for bathing, but for drinking. Besides the hot springs, the effects of which as drinking waters are pronounced, there are magnesia, sulphur, and soda springs within the grounds, and alum water from a spring not far distant. The water from the soda spring comes strong and clear from the ground at a uniform temperature of 74 degrees. Physicians should address for full information Christian S. Andersen, Esq.

The Canadian Journal of Medicine and Surgery

A Journal published monthly in the interests of Medicine and Surgery

Vol. XLVI. TORONTO, DECEMBER, 1919 No. 6

Editorials

EDITORIAL EXPANSION

WE are pleased to announce several additions to our Editorial Roster.

Dr. Duncan Graham, the new professor of medicine in Toronto University, we mention first. Born near London, Ontario. M.B. Tor. in 1905. One year in the laboratory of the Provincial Board of Health with Amyot, where with Nasmith made researches into carbon monoxide poisoning; was Interne in pathology at the General Hospital the following year. Two years followed as Director of Laboratories with White at Pittsburg. Six months followed at London Hospital; the next six in Dresden; the next six at Heidelberg; the next six in Vienna. Three years followed as lecturer in Bacteriology in his Alma Mater. The next six months were spent in Berlin. These visits abroad were spent in pathology and medicine. He went overseas in 1915,

and was attached to the Duchess of Connaught Hospital at Taplow. From there he went to France in charge of the laboratory of the 2nd Canadian General Hospital. Following this he went to Saloniki in charge of No. 4 Canadian Hospital laboratory. Returning to England he became chief in medicine in Basingstoke Hospital. Lieutenant in 1914, he attained his Captaincy in the same year, Major in 1917, and Lieutenant-Colonel in 1918. He was mentioned in despatches in 1917. Has published articles on carbon monoxide poisoning; the increased infective power produced in bacteria by sensitization with normal serum of the same species, reaction of sera on tuberculin cutaneous reaction, a quantitative modification of the von Pirquet tuberculin reaction and its value in diagnosis and prognosis; an index to tuberculin treatment in tuberculosis by the minimal cutaneous reaction method; luxus-konsumption; ueber die anpassungsfahigkeit des tierschen organismus an uberreichliche nahrungszufuhr; intersuchungem ueber isolyse; ueber hæmotoxins und die Blutplatten methode, streptococcus bacteriaemia in endocarditis; some points in the diagnosis and treatment of dysentery occurring in the British Saloniki Force. We hope to publish a few such contributions by Prof. Graham.

Dr. W. B. Hendry served during the war with No. 4 Canadian Hospital. Leaving Canada as captain he duly attained the rank of colonel. Was mentioned in despatches and proved a most successful soldier. He succeeded Col. Roberts in charge of

No. 4, and showed himself a very able administrator. Dr. Hendry has recently been appointed as associate professor in gynecology in the Medical Faculty of Toronto University. As a student, Dr. Hendry had a fine career. A son of one of the best principals of Toronto schools, he took every step in the much-maligned educational ladder from A.B.C. to B.A. He became a successful teacher in Bishop Ridley College, St. Catharines. When his pockets were sufficiently lined with his pedagogic pittance he essayed medicine, graduating M.B. in the early oughties. Being both a physician and scholar we shall look for special help from the ready pen of Dr. Hendry.

Dr. George Strathy, clinician medicine, University of Toronto, was in charge of the department of medicine at the Ontario Hospital at Orpington. After taking a strong course in medicine at the University, Dr. Strathy spent two or three years of interneship in the Hospital for Sick Children and in the Toronto General Hospital, where he acquired a reputation for careful clinical observation and record-taking. He is now specializing in internal medicine. He made a special study of trench fever, a resumé of which appeared in one of our recent numbers.

Dr. Stanley Ryerson went overseas with No. 4 Canadian General Hospital, where he did excellent work. Returning, he was appointed A.D.M.S. to No. 2 Military District, succeeding Col. Frederick Marlow. For some time past he has done the secre-

tarial work of the University Medical Faculty and served as assistant in surgery in the Toronto General Hospital and on the University teaching staff. Dr. Ryerson has prepared numerous papers on surgical subjects, and we hope to publish some of his work in the near future. Dr. Ryerson is surgeon-in-chief to the Department of Soldiers' Civil Re-establishment for this district.

Dr. Gordon Gallie also won his spurs in connection with No. 4 Canadian Hospital in Macedonia. He is attached to Prof. Watson's Service at the Toronto General Hospital and in the Medical Faculty of the University—one of the rising younger men of the profession. He is brother of Dr. W. E. Gallie, the well-known orthopedic surgeon.

Dr. Alan Canfield graduated in the early 0's, and took special training at the Sick Children's Hospital and at the Toronto "General" on the interne staffs. He repidly made good as a pediatrist. He is a member of the visiting staff of the Hospital for Sick Children, and a frequent contributor to medical literature.

Dr. Geo. E. Smith makes a specialty of children's diseases and affections due to foreign protein infections. He has done a lot of work on infant feeding, on chorea in children, and kindred topics. His papers make excellent reading.

MEDICAL ETHICS

THE subject of medical ethics bobs up perennially. It was discussed the other day in New York by the American Surgical Association, and has been under consideration by the Academy of Medicine, Toronto. The subject which seems most to agitate the committees on ethics of these bodies is that of fee-splitting.

At the New York meeting a very prominent surgeon said there were two classes of fee-splitters: one was the man who had grown fat in practice, became rich and wished to join a reputable association. He would be good now that he is well off. "That man," remarked the big surgeon, "should be told to go to Hell. The other sort was the young man who has been in the habit of splitting fees and has come to the conclusion deep in his heart that he is doing wrong. Robed in sack-cloth and ashes, he acknowledges his sin and seeks admission to the association. Under these circumstances we tell him that the sinner may return even at the eleventh hour or even at 11.45."

One of the older and best-informed surgeons of Toronto, and one of the most highly-respected, stated with emphasis at a recent Academy meeting that "at the present moment in Toronto unnecessary surgical operations are being performed, and I see no attempt made to stop this wrong. What is the Academy of Medicine going to do in the premises?"

Every code of ethics, declared a medical consultant, should contain the Hippocratic oath; and he read the complete oath for the benefit of the Fellows

assembled. "When thy patients ask for a poisonous drug, administer it not." This stand should be taken by practitioners to-day when *asked* for a prescription for whiskey.

One Fellow declared that the University should lay more stress on the teaching of ethics to medical students, while a venerable general practitioner present declared that the younger practitioners were considerably more ethical than the older generation. " Honesty and common decency," declared one of the high-browed men of the old school, should be sufficient without any published code. In this he was supported by another gentleman of the old school, who instructively does and says the right thing in the right time and place.

The whole matter is summed up in the Golden Rule, was the verdict of others.

One of the older and finer types lamented that the lay press should announce that surgeon so and so had been rushed by special train to attend a patient. His own moves to see patients never got into the papers.

"It's alright for certain big fellows to talk about ethics," remarked one of the silent members in the seats, "but some of them are as big sinners as any of those they are condemning."

Canadian Journal of Medicine and Surgery

Editorial Staff

Surgery:

N. A. Powell, M.D., C.M., Professor of Medical Jurisprudence, University of Toronto.

Clinical Surgery:

Alexander Primrose, M.B., C.M.G., Professor of Clinical Surgery, University of Toronto; Herbert A. Bruce, M.D., F.R.C.S., Eng., Surgeon, Wellesley Hospital, Toronto.

Orthopedic Surgery:

Clarence L. Starr, M.B., Professor of Orthopedic Surgery, University of Toronto; W. E. Gallie, M.D., F.R.C.S., Eng., Associate Surgeon, Hospital for Sick Children, Toronto.

Army Medical Services:

Lt.-Gen. John T. Fotheringham, M.D., C.M.G., Director of Medical Services of Canada; Col. W. B. Hendry, B.A., M.B., late Officer Commanding No. 4 Canadian General Hospital; Lt.-Col. Stanley Ryerson, M.D., Toronto, late Assistant Director, Medical Services, No. 2 M.D.

Medical Jurisprudence:

Arthur Jukes Johnson, M.B., M.R.C.S., Eng., Chief Coroner for the City of Toronto; W. A. Young, M.D., L.R.C.P., Eng., Associate Coroner for the City of Toronto.

Hospital Administration:

J. N. E. Brown, M.D., Toronto, former Superintendent Toronto General and the Henry Ford Hospital, Detroit; A. K. Haywood, M.B., M.R.C.S., L.R.C.P., Eng., Medical Superintendent, Montreal General Hospital; Helen MacMurchy, M.D., Toronto, Assistant Inspector of Hospitals for the Province of Ontario.

Nose, Throat and Ear:

Perry G. Goldsmith, M.D., C.B.E., Senior Assistant, Ear, Nose and Throat Department, Toronto General Hospital.

Pediatrics:

Allen Baines, M.D., Emeritus Professor of Pediatrics, University of Toronto; Alan Canfield, M.D., Visiting Physician, Hospital for Sick Children, Toronto; George Smith, B.A., M.B., Associate Physician, Hospital for Sick Children, Toronto.

Medicine:

Duncan Graham, M.D., Professor of Medicine and Clinical Medicine, University of Toronto; Alexander McPhedran, M.D., Emeritus Professor of Medicine, University of Toronto; Lewellys F. Barker, M.D., Baltimore, Emeritus Professor of Medicine, Johns Hopkins University.

Clinical Medicine:

H. B. Anderson, M.D., Emeritus Associate Professor of Clinical Medicine, University of Toronto; George S. Strathy, M.D., L.R.C.P., M.R.C.S., Eng., Clinician, Department of Medicine, University of Toronto; H. K. Detweiler, M.B., Clinician, Department of Medicine, University of Toronto.

Mental and Nervous Diseases:

N. H. Beemer, M.D., Medical Superintendent, Ontario Hospital, Mimico; Campbell Meyers, M.D., M.R.C.S., L.R.C.P., Eng., Private Hospital, Deer Park, Toronto.

Gynecology and Obstetrics:

B. P. Watson, M.D., F.R.C.S., Edin., Professor of Gynecology and Obstetrics, University of Toronto; J. Gordon Gallie, B.A., M.D., Assistant, Department of Obstetrics and Gynecology, Toronto General Hospital; A. C. Hendrick, M.A., M.B., F.R.C.S., Edin., Demonstrator in Gynecology, University of Toronto.

Pathology:

J. J. Mackenzie, B.A., M.B., Professor of Pathology and Bacteriology, University of Toronto.

Ophthalmology:

J. M. MacCallum, M.D., Senior Assistant, Eye Department, Toronto General Hospital; Walter W. Wright, M.B., Assistant in Ophthalmology, Toronto General Hospital.

Dermatology:

D. King Smith, M.B., Clinician, Department of Dermatology, University of Toronto.

Managing Editor:

W. A. Young, M.D., L.R.C.P., Eng., Toronto.

Address all communications to "The Canadian Journal of Medicine and Surgery," 145 College Street, Toronto, Canada.

Doctors will confer a favor by sending news, reports and papers of interest from any section of the country. Individual experience and theories are also solicited. Contributors must kindly remember that all papers, reports, correspondence, etc., **must be** in our hands by the first of the month previous to publication.

Reprints supplied at Net Cost

Original Contributions

THE DIAGNOSIS AND TREATMENT OF SUPPURATION IN THE MAXILLARY ANTRUM

PERRY G. GOLDSMITH, C.B.E., M.D.C.M.

Senior Assistant Surgeon, Oto-Laryngological Department, Toronto General Hospital

Acute and chronic inflammation of the lining membrane of Highmore's antrum is one of the most frequent causes of nasal complaints since it is almost always associated with those inflammatory phenomena which we know as coryza or cold in the head. Hence it is not uncommon also in influenza, pneumonia, measles, scarlet fever, and may even result from nasal sepsis following intra-nasal operations or injudicious packing. Practically all coryzas associated with purulent nasal discharge indicate probable involvement of a nasal accessory sinus. The antrum of Highmore is the one we most commonly meet, since nature takes care of the other sinuses much better.

This is not difficult to understand, in fact is to be expected when one considers the anatomy of the outer wall of the nose. The nasal mucous membrane is, generally speaking, lined with ciliated epithelium, which is continued into the maxillary antrum through the natural ostium in the unciform groove or an accessory opening which is present in about twenty-five per cent. of cases.

Furthermore the close relationship existing between it and the last two molar and the first bicuspid teeth renders dental infection easy since a layer of mucous membrane only may exist between them. Dental caries, root infection, is directly the excitant of antral suppuration in thirty-three per cent. of cases.[1] This percentage would now, I think, be considered too

high, as it cannot exclude infection from the nose as well. Occasionally I have been able to feel a projecting fang in the floor of a chronic antrum when performing a radical operation, but in which no evidence of any dental inflammation existed.

Briefly, then, there are two causes of infection: (1) Nasal, the most common, and (2) dental. The former may take the role of a simple acute rhinitis, local or associated with some other acute disease in which rhinitis is a frequent association. The latter may be associated with acute or chronic root inflammation or follow difficult or unskilled root extraction.

Anatomy.

This hollow space inside the cheek bone varies greatly in size. It may be a mere chink or hold as much as an ounce of fluid. It is pyramidal in shape, with the base toward the nose and its apex to the outer part of the superior maxilla. Above it forms the floor of the orbit, and in it is found the infraorbital nerve, while below it forms the upper boundary of the roots of some of the teeth in the upper jaw, particularly the molars and first bicuspid. Posteriorly it forms the anterior boundary of the pterygoid fossa, while in front it is mostly in relation with the canine fossa in which situation the bone may be very thin. The base, which is the most important boundary, corresponds to the outer wall of the middle and inferior nasal meati. This wall is divided into two portions by the attachment of the inferior turbinal bone, the superior portion corresponding to the outer wall of the middle meatus and leaving in its upper and back part an opening, the natural ostium, while the lower part is in relation to the outer wall of the inferior meatus and is marked by a slight ridge showing the situation of the lower end of the lacrymo-nasal duct. The upper portion is thin and composed of both bone and membrane, but the lower part is made up of bone of varying thickness, but thinnest immediately below the point where the turbinal flange ends.

From this it will be noted that we have a secreting membrane in a large cavity, the floor of which is generally lower than the floor of the nose, and which has its natural ostium near the roof. It is not surprising, then, that once infection

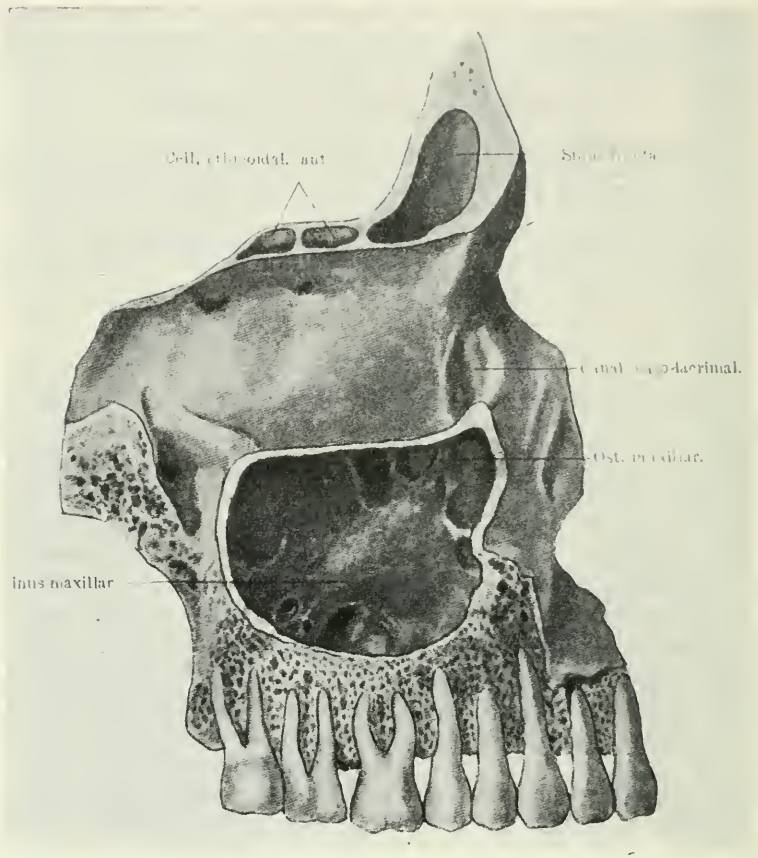


PLATE I.

Dissection showing the right maxillary sinus opened upon its outer aspect. The ostium maxillare is seen situated immediately below the roof of the cavity. The outer table of bone is removed in order to show the relation of the fangs of the teeth to the floor of the antrum. Anterior ethmoidal cells are seen passing into the roof of the orbit behind the frontal sinus.
—*Logan Turner.*

takes place in the antrum there is little chance of its terminating without the formation of considerable exudation.

A further study of the region of the natural ostium from the nasal side aids us in comprehending how easily the intricate drainage system may be completely disorganized. The unci-

form groove may no longer resemble a gutter, if in the presence of a chronically inflamed nasal mucous membrane there is also a prominent bulla and an hypertrophied lip of the uncinate process. If to this is added an enlargement of the anterior portion of the middle turbinal the uneiform groove may resemble a tube or resemble somewhat a blind sac.

Pathology.

J. S. Fraser, of Edinburgh, writes very thoroughly on the changes that take place in the antral mucosa.[2] He shows that these changes are analogous to those that take place in the nose in catarrhal and suppurative rhinitis, and in the middle ear cleft in catarrhal and suppurative otitis media. Quoting Oppekofer, he points out that the changes in the mucosa are not uniform, but vary in different parts, and ulceration with bony necrosis almost never exist. In an examination of the mucous membrane in nineteen cases of acute and chronic sinusitis, Fraser found only one acute specimen, and that in a sphenoidal sinus, obtained at autopsy on a case of pneumonia. In this instance the mucosa was thickened, deep red in color with a velvety surface. The sinus contained thick muco-pus, but no blood. Microscopically the prominent feature was the extensive hemorrhage in the sub-mucous tissue and the engorgement of the blood vessels. The superficial epithelium was in places markedly degenerated.

In the cases of chronic inflammation it was noted that the superficial layer might be apparently normal, although there were marked changes in the submucous tissue. The number of "ghost" cells in the superficial layer is often large. Hajek has shown that in the nasal mucous membrane these cells are associated with a discharge of mucus and thinks it is almost certain that the same obtains in the accessory sinus.

In most of Fraser's specimens leucocytes were seen making their way between the epithelial cells to the surface, there to mix with the mucous secretion and form the muco-purulent or purulent exudation characteristic of sinus catarrh or suppuration.

Micro-organisms.

In the chronic cases no organisms were found in the tissues of any case, but only from the surface discharge. Lack is quoted as expressing the view that there is no definite evidence as present to show that a particular organism or mixture of organisms is associated with any definite sort or degree of inflammation.

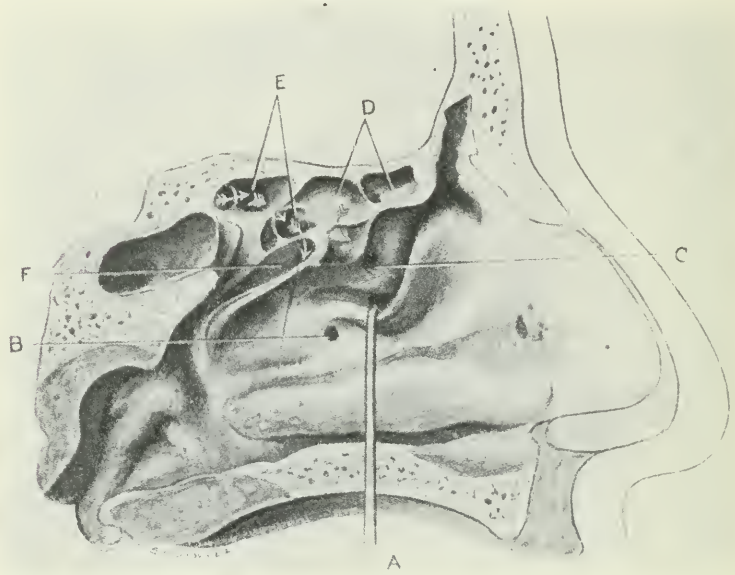


Plate II.

A. Hook drawing down the inner lip of the hiatus semilunaris, so that the opening into the maxillary antrum can be seen.
B. Accessory opening into antrum.
C. Opening of ethmoidal into middle meatus.
E. D. Superior ethmoidal cells opening into—
F. The superior meatus. —*Herbert Tilley.*

Symptoms of Acute Maxillary Sinusitis.

These are so generally associated with the acute manifestations of the associated and causative coryza, that for the moment the sinus infection is masked. The malaise, nasal obstruction, headache and pain over the front and side of the head,

which accompanies all coryzas, is often associated with two definite symptoms pointing to involvement of the maxillary antrum, viz., pain in the cheek increased on leaning forward and tenderness in the canine fossa. When this is associated with a purulent discharge from the corresponding nostril, the diagnosis becomes more positive. The position of the pus in the nose is very important since it is in the middle meatus between the anterior end of the middle turbinal and the outer wall of the nose that pus from the antrum is first seen. True, it may come in this situation from the anterior ethmoidal cells or the frontal sinus. If, however, the pus is wiped away and the patient's head tilted forward and to the opposite side, a rapid reappearance of the discharge is strongly presumptive of a collection of secretion in a cavity, the opening of which is higher than its floor, that is the maxillary antrum.

Additional diagnostic aids are suction and transillumination. The value of the former is lessened owing to the ethmoid and frontal being also acted upon, which the latter may be deceptive, owing to a thickened bone, a thickened membrane from former chronic inflammation or the presence of a large cyst in which the diseased side may transmit the light much more than the healthy side.

One must not forget to remove a dental plate or any nasal packing before transilluminating. This is a diagnostic aid, very frequently reliable in acute cases, but it is the experience of all rhinologists that pus is not infrequently found when transillumination points to its absence.

The X-ray is seldom required for acute cases, and is of very limited value. In acute inflammation of chronic empyema or chronic cases the skiagraph is of much more value. Not only can one gain knowledge of the presence of septa and size of the antrum, but he can at the same time gain evidence of the presence or otherwise of disease in the ethmoid frontal and sphenoid. The rare cases in which a foreign body is present in the antrum are, of course, spotted at once.

Proof Puncture.

It is only by irrigation of a sinus that the presence or otherwise of secretion can be *positively* affirmed. This is made by

a fine trocar and cannula passed through the naso-antral wall and followed by a watery solution, the return flow being caught in a black basin. Pus, mucous and epitheloid debris show up much better on a black background.

The puncture may be either in the inferior meatus, close

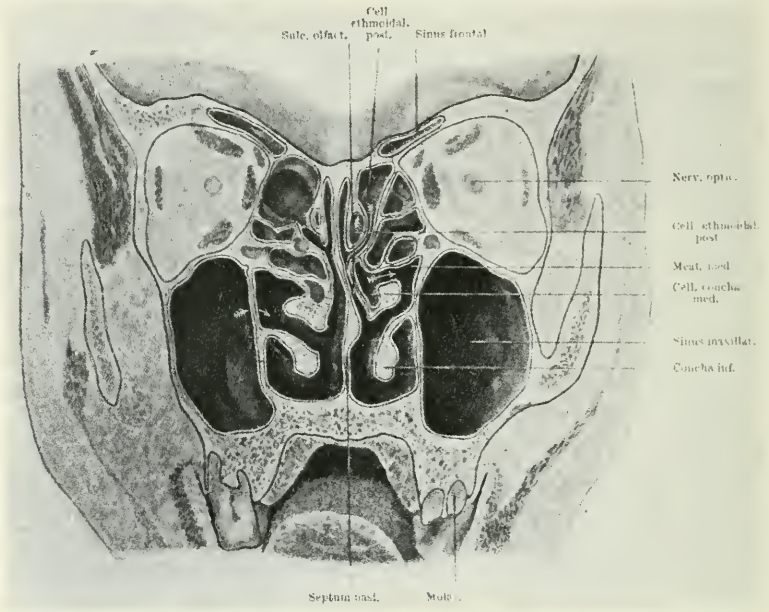


PLATE III.

Drawing from a frozen section, kindly lent to the author by Prof. Symington. The vertical coronal section through both nasal chambers and maxillary antra is made on the plane of the first molar teeth, and is viewed from in front. On the right side an arrow indicates the position of an accessory maxillary ostium. On the left side the posterior ethmoidal cells are seen opening into the olfactory cleft and a middle turbinal cell into the middle meatus. The section also shows the frontal sinuses extending for a considerable distance backwards along the roof of the orbit.—*Logan Turner.*

to the flange of the turbinal, where it turns downward and where the bony wall is thin or in the middle meatus. If the latter route is chosen, Watson Williams' syringe and canula form a rapid and excellent way of determining the contents of a maxillary sinus. Failure to get a return flow from the sinus may be due to (1) not having gone far enough back in

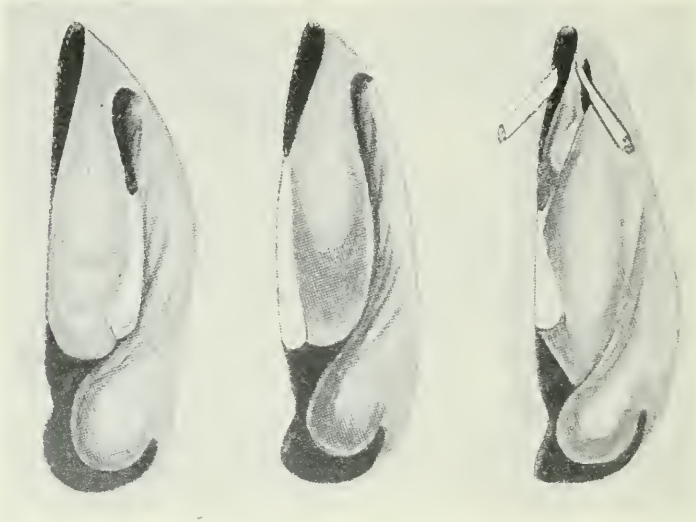
the nose and hence being in the cheek in front of the sinus, (2) the tip may be in a mass of polypoid tissue or imbedded in a thickened membrane on the opposite wall; (3) the cavity being filled with polypi or new growth mechanically obstructing the ostium from within; (4) extreme swelling of mucous membrane of the unciform groove with the presence of a large cystic middle turbinal. Withdrawing the cannula a short distance and again trying to syringe through may be successful.

Treatment of Acute Cases.

If there are any diseased roots of the teeth in relation to the floor of a suppurating antrum, they should receive appropriate dental attention. If the teeth are extracted, and even though they extend into the antrum, alveolar drainage is practically no longer practised or recommended. The patient is better in bed and appropriate measures taken, directed to controlling the acute nasal catarrh, such as calomel and salines, liquid diet and diaphoresis. Our most important objective is ventilation and drainage of the cavity, and to this end the cleft between the middle turbinal and the outer nasal wall is packed with wool or gauze saturated with a five or ten per cent. solution of cocaine, to which is added a little adrenalin. This aids greatly, not only in relieving the discomfort by removing pressure, but assists very materially in rendering the ostium patent. Hot saline douches in the nose, or as Lack says, scarifying the anterior end of the middle turbinal tend to lessen the turgescence in the unciform groove. Posture may aid us very much. Waggett[3] speaks very highly of the method by which a patient lies down in such a position that the ostium comes to be the lowest point of the antrum.[4] He must lie with his head almost inverted, the superior parietal region of the sound side resting upon the mattress, while the shoulders are raised upon pillows. Hours, he says, may profitably be spent in this attitude. The use of a suction pump has many warm advocates. Inhalations of benzoin or pine in hot water or an alcoholic mixture of menthol in the same manner aid in lessening the nasal congestion.

If rapid improvement does not follow these simple measures it is better to irrigate the sinus through an artificial opening.

The natural ostium is now seldom used. The cavity may be syringed out in the same way as described in making a proof puncture for diagnostic purposes. It is not necessary to remove any portion of either turbinal to pass the trocar. My own practice has been to use a fine Lichtwitz trocar and canula, which, after cocainizing the outer wall of the inferior meatus is passed through the antro-nasal wall directly below the attach-



1 2 3

PLATE IV.

(1) Pus from under the middle turbinal, indicating empyema of the frontal sinus, anterior ethmoidal cells, or maxillary antrum.

(2) Pus from above the middle turbinate, indicating empyema of the sphenoidal sinus or posterior ethmoidal cells.

(3) Much enlarged unciform cushion, simulating the middle turbinate. Exposure of the true middle turbinate by the use of retractors.—*Waggett.*

ment of the inferior turbinal bone. More familiarity with the various instruments used in sinus exploration, together with a personal visit to Dr. Watson Williams, of Bristol, England, where the excellence and rapidity of his methods have my heartiest admiration, leads me to employ his suction syringe much oftener. Lavage of the antrum is, in the vast majority

of cases, easily and rapidly carried out, and is not particularly painful. One must remember, however, that in acute cases or in cases where an acute exacerbation of an old condition exists, this simple procedure may not only cause very severe and long-continued pain, but also profound shock. A sharp trocar, great patience and gentleness are essential. Very gentle syringing at first may avoid great distress. If the case be an acute one grafted upon a chronic empyema the viscidity of the secretion may cause considerable delay and difficulty for the return flow to appear in the nose. In acute cases the discharge may appear at first as a reddish brown secretion, but all variations to pure yellow pus may occur. Occasionally the odor is very foul, and this suggests a dental origin, even though no clinical evidence is present.

As soon as the effect of the syringing has worn off, and this may take an hour or more, the patient is greatly relieved, his nasal inflammation considerably reduced, and his sense of well being greatly improved. The dependent posture may then be sufficient to permit of adequate drainage and resolution follow in a short time. It may be that repeated irrigations will be required, and it is then one's nicety of touch and direction that permits his entering the same hole every time. I am satisfied that it is not the chemical formula of the solution used, nor the mechanical removal of the products of the inflammation that brings about the great relief and rapid cure. Ventilation takes a much more important place in the treatment and does not receive the credit it deserves.

The pain in acute antral cases may be greatly lessened by the use of a hot compress or hot water bag to the face, but it is necessary occasionally to administer aspirin, phenacetine or even morphia. Wrapping the head and face in a hot flannel shawl often gives great comfort. If blowing the nose frequently and forcibly does not cause any marked discomfort it should be encouraged.

The difficulty in securing intra-nasal ventilation and drainage may be associated with various degrees of nasal obstruction, such as enlargement of the anterior end of the middle turbinal, marked hypertrophy of the covering of the inferior

turbinal, or the presence of a large bulla ethmoidalis, with or without hypertrophy of the membrane covering the anterior lip of the unciform groove. High deflections of the nasal septum with the convexity toward the affected antrum are frequently found. After the acute infection has subsided appropriate treatment to the nasal obstruction may be required either

PLATE V.

Shows the method of introducing a Lichtwitz trocar and canula into the antrum through the inferior meatus.

In order to show the proper point of entry through the antro-meatal wall, a part of the inferior turbinal body has been removed, but no part of the turbinal body is cut or removed in practice.—*P. Watson Williams.*

to prevent a chronic inflammation taking place or a recurrence with each subsequent acute nasal catarrh.

How long one should persist in irrigating an acute suppurating sinus is difficult to say. It must be remembered that too energetic treatment is unwise, too frequent irrigations may tend to keep up the discharge, and the use of strong disinfectants is not generally advised.

Not infrequently, when we have almost concluded that some

form of permanent drainage is advisable, we are agreeably surprised how rapidly the case recovers after all treatment has ceased. Change of air, a trip to a warmer climate, or to the seaside often leads to a rapid clearing up of all discomfort and discharge.

It may be stated that if, after all acute manifestations in the nose have ceased and there are no evidences of any other sinus on the same side being involved and the return flow is still markedly muco-purulent, some form of counter-drainage will be required.

One should, I think, take into consideration the age, occupation, social and physical condition of the patient. This has been thoroughly discussed by Ross Skillern[4] in determining when to operate on the chronic cases. Furthermore, it is well to remember Sir Felix Simon's advice, "A person may go through life, yea, even enjoy life, with a suppurating maxillary antrum." When one has taken into consideration all these points, and it is still considered wise to employ further operative measures, a resection of the antro-nasal wall in the inferior meatus should be the operation of choice. This will be further discussed in dealing with the treatment of the chronic form.

Chronic Suppuration Symptoms.

A sinus with a history of long continued suppuration may have an acute infection grafted on its chronic state. This usually takes place during an acute rhinitis. The symptoms while not so severe so far as pain and discomfort in the antrum are concerned, are generally associated with a greater and more offensive discharge from the nose.

Lavage alone may result in cure in a few cases, but the duration of this method of treatment is likely to be very trying both to the patient and surgeon. The use of disinfectants does not appear to act further than lessen the odor.

The diagnostic methods mentioned in acute cases all apply to the investigation of a chronic empyema but with an added significance in the case of transillumination and the X-rays. The latter gives information as to the presence of septa and partial partitions. The presence of a large cyst

may make the *healthy* antrum appear the more cloudy on the plate.

As in acute cases the only diagnostic method of any real value is exploratory puncture. One must not too readily decide that the antrum is clear because the first part of the fluid returns clear. This is shown very forcibly in a case I recently saw in which all the clinical signs of a chronic empyema existed, yet it was only after a pint of fluid had passed through the antrum before evidence of extensive disease was elicited. At the radical operation in this case the antrum was found nearly full of a caseous material which could be lifted out with a scoop, and in appearance and consistence resembled very much the ordinary cholesteatoma found in the mastoid and middle ear in chronic middle ear suppuration. Prior to irrigating any sinus it is wise to see that all secretion is removed from the nasal cavity so as to be sure that whatever secretion comes away has been secreted by the cavity under examination.

Treatment of Chronic Suppuration.

The guiding principles of treatment should be:

(1) Permanent ventilation and drainage.

(2) Removal of polypoid mucous membrane in the antrum.

(3) Prevention of reinfection from any associated sinus disease.

It has been advised by Skillern that before attempting any surgical measures, the effect of gradually increasing injections of alcohol or silver nitrate should be tried. My own experience with chronic cases does not lead me to view any form of local treatment with favor. I attach much greater importance to dental attention where removal of diseased or septic roots may very materially aid a regeneration of the antral mucosa after the radical operation has been carried out. As to acute cases, I do not favor alveolar methods of treatment or so-called drainage.

Children are not very common among our antral cases, probably because the smallness of the cavity assists a rapid cure. When present as a chronic disease intra-nasal meas-

ures without general anesthesia being usually impossible, some sort of radical operation, the simpler the better, will be required. The frequency with which the ethmoidal labyrinth is involved in the young suggests attention to this area and thorough drainage here is often followed by cure of the antrum without any other treatment. Mosher has pointed out that the ethmoidal labyrinth often overhangs the antrum at its inner and posterior corner.

The general condition of the patient should always be considered before any operation is undertaken. Chronic nephritis and diabetes are indications which should cause careful consideration as to the advisability of any serious operative procedure. The aged, whose recuperative powers are not good and on whom shock is a serious condition, should be subjected to as little surgical interference as possible.

Intra-Nasal Operation.

The removal of a portion of the inferior turbinal bone is nearly always essential to securing a permanent opening in the external wall of the inferior meatus. The anterior end is usually removed with scissors and snare. Some operators regard the anterior end of such physiological importance that the middle portion is removed. This for me makes the operation more difficult, and I have not yet regretted having removed the anterior portion. The operation is performed under local anesthesia. A weak solution of cocaine, say five per cent., is applied to both sides of the inferior turbinal, and after waiting for twenty minutes or half an hour a stronger solution is brushed along the antro-nasal wall. It is better to use weak solutions with adrenalin and wait longer than secure a rapid anesthesia with the danger of toxic symptoms from cocaine.

After the turbinal portion is removed the dividing wall is rapidly removed, using various chisels or burs, according to the operator's fancy and experience. The opening may be enlarged both anteriorly and posteriorly with cutting forceps, of which Ostrom's is a satisfactory type. In thin walls this is rapidly and easily performed, but where the bone is dense and thick difficulty may be experienced in securing an opening

which is sufficiently large to be permanent. There is a great tendency for this opening to close, hence a large one is very desirable. Packing the nose and antrum is undesirable, but the subsequent bleeding from the stump of the turbinal frequently necessitates gentle nasal packing with gauze impregnated with some bismuth or other ointment, to facilitate removal, which should take place not later than twelve or twenty-four hours. It is best to leave the nose alone then for a few days, when intra-nasal irrigations may again be practised. The patient can easily be instructed how to pass a well curved Eustachian catheter into his antrum and irrigate it daily. When the opening is large any good douche directed to the outer wall of the nose low down will probably do as well. If intra-nasal measures are to be sufficient to cure the patient, he has the cure in his own hands. Varying the solution from time to time is helpful, while the use of weak zinc salts is especially so when the discharge becomes mainly mucous or consists of a small mucoid mass or blob. Prolonged douching seems to keep up the mucous discharge in some cases, and if the nose is then left alone for a week or two one often finds no further necessity for any treatment. This form of treatment will be sufficient for a considerable number of cases, probably in those where chronicity with marked changes in the antral mucosa has not been long established. Even if it fails, one has the satisfaction of knowing that a part of the radical operation has already been carried out.

Operation Through the Canine Fossa.

The advantage of an operation that permits direct inspection of the diseased area is obvious to all surgeons. As the canine fossa enters so largely into the formation of the anterior wall of the antrum, opening through this area fulfills all our requirements. "The original operation of Desault and Küster consisted in opening the canine fossa and carrying out all subsequent treatment through this aperture. Unsatisfactory results followed, principally because the disease was not always cured and was frequently followed by a buccal fistula. Scanes Spicer modified the procedure by adding to it intra-nasal drainage as described above under intra-nasal operations. Subse-

quently the names of Caldwell and Luc became associated with this modification and the operation is now known as the Caldwell-Luc operation." [5]

Various other procedures have been advocated, each having the common aim of securing direct inspection of the antral cavity. The Denker operation is probably the best known and aims to do away with the angle formed by the anterior extremity of the outer nasal wall in the inferior meatus and the corresponding front wall of the superior maxilla.

The writer favors the Caldwell-Luc operation, and it alone will be considered. This operation reaches the antrum by reflecting the mucous membrane and periosteum from the canine fossa, the upper lip being well retracted to permit of easy access.

The bleeding is easily controlled by pressure and any excess is caught in a gauze pad placed in that side of the mouth. With care one may remove sufficient bone without disturbing the lining of the cavity. This is desirable since it permits of a large portion of the diseased lining being removed by simply separating it from the antral walls with a curved thin separator. When any membrane is removed from the antrum bleeding rapidly obscures the field and considerable time will be saved if the cavity is packed for five minutes. While waiting the time may be profitably spent in enlarging the cavity with bone forceps and removing any corners or spiculae present. The opening should reach the level of the antral floor and sufficiently well forward to secure a clear view of the antro-nasal wall.

Sufficient time having elapsed to presume a clear field the packing is removed and a thorough inspection of the cavity made. I always palpate the cavity thoroughly and secure valuable information as to the depths of the recesses and the thickness of the diseased membrane.

Septa forming pockets and all polypoid tissue are now thoroughly removed, taking care not to injure the infraorbital nerve in the roof. One must not try to remove all the mucous membrane, as this results in the excessive formation of granulation tissue, rather he should be sure to leave rather large islands of mucosa from which subsequent growth can extend.

I have found wiping vigorously the cavity with gauze of value, and I suggest the use of a burr covered with layers of gauze or similar material which could be made to revolve rapidly and thoroughly clear out all the angles. In cases where there is not a marked change in the mucosa it is questionable if any curettage is desirable.

When one has satisfied himself that all the nooks and corners of the cavity have been carefully cleared he is then ready to remove the antro-nasal wall. This is best achieved by the use of a flat chisel and mallet, taking care not to pierce the nasal mucosa. By avoiding this bothersome hemorrhage is avoided and a more thorough and systematic removal of the bony wall is accomplished. This membranous wall is then removed with a narrow knife or it may be turned down over the cut edge of the bony wall and lie in the floor of the antrum. This is advised by Boenninghaus, and I have found it an added refinement to the operative technique.

If there is associated with the antral disease a similar condition in the ethmoidal region with the formation of nasal polypi this area should receive appropriate attention. Considerable attention has probably been bestowed on this region under local anesthesia on a prior occasion and little may now be required. It is frequently very easy to secure satisfactory ethmoidal drainage by attacking the ethmoid through the upper and inner antro-nasal wall. Mosher's method is the one I usually employ. The anterior end of the inferior turbinal, if not already removed, is now taken away.

There is some difference of opinion as to the advisability of packing the nose and antrum after this operation. The ethmoidal region should never be packed since meningitis has been known to follow. There does not seem to be any valid objection to a strip of gauze being placed through the antro-nasal opening and against the turbinal as it lessens the liability to prolonged oozing of blood and is very easily removed the following day. I am not in the habit now of suturing the buccal wound. Formerly I did so, but I have seen no advantage follow.

Pain in the face is not unusual for the first twelve hours, depending, I think, very much on how roughly the cheek has

been retracted. I usually order a small dose of morphia to ensure a quiet night. All packing is removed the next day and no more inserted. It is a good rule to leave the nose alone for a few days. The patient should not blow the nose, rather he should draw the secretion back and expectorate it.

Softening the nasal vestibule with oil or vaseline adds to the patient's comfort, while the use of a hot water bag relieves the feeling of tension and pain in the cheek. Cold is preferred by some, but heat has been found in my cases more agreeable.

On the third or fourth day the patient may be encouraged to blow the nose gently, taking care to support the cheek with the hand so as not to blow open the buccal wound. Gentle irrigations with warm saline or boracic solutions may now be commenced, using at least a pint each time.

The reaction following the operation varies in different people. Some have to remain in bed as long as two weeks while others are up in a few days. Feeble and neurotic women or those past middle age often suffer considerable shock.

In cases complicated with ethmoidal disease it is generally necessary to remove hanging tags and small bony spiculæ after the first week or so. We should deal very gently with this area.

The patient is now ready to be shown how to irrigate his own antrum and may do so without any other treatment for the next few weeks, when he will be practically well, especially if the antrum alone is involved. An oil spray is grateful to the patient in that it tends to keep soft the dry crusts which form during the healing process.

Complications.

It is seldom one meets with any unusual reaction following radical antrum operations. Shock, meningitis, and septic infection have occurred. The first two are treated on general surgical principles, while the third is rapidly controlled by frequent nasal irrigations with mild alkaline solutions.

The altered condition of the antral mucous membrane, together with the drying effects of a greatly increased air circulation in a cavity nature never intended to be so exposed must

result in occasional collections of mucoid secretion. This may also occur during any subsequent head cold, but the presence of good drainage makes for little or no discomfort and whatever inconvenience ensues is rapidly relieved by the patient irrigating once or twice the antral cavity.

REFERENCES.

[1]Logan Turner and C. J. Lewis.—Ed. Med. Jour., Apl., 1910.
[2]Journal of Laryngology, Vol. XXIV, No. 9, Sept., 1909.
[3]Diseases of the Nose. E. B. Waggett, 1907.
[4]Journal of Laryngology, Jany., 1916.
[5]Diseases of the Nose and Throat. By Sir St. Clair Thomson.

84 Carlton St.

Society Proceedings

REPORT OF THE EXECUTIVE MEETING OF THE ONTARIO MEDICAL ASSOCIATION

Held in the Academy of Medicine, Toronto, Wednesday, Sept. 24th, 1919.

At this meeting of the Executive, many matters of interest to the medical profession in Ontario were discussed and arranged.

Pursuant to instructions laid down at the last annual meeting of the Association, the Executive divided the Province of Ontario into ten counsellor districts. This step was deemed advisable in order that each counsellor might have a territory which would enable him to render the best service to the profession in general and the Association in particular.

The following is a list of the Executive as now constituted: President, Dr. F. W. Marlow, Toronto; First Vice-President, Dr. J. H. Mullin, Hamilton; Second Vice-President, Dr. J. H. Farley, Trenton; Honorary Treasurer, Dr. G. Stewart Cameron, Peterboro; Honorary Secretary, Dr. T. C. Routley, Toronto; Dr. J. A. Macgregor, London; Dr. E. R. Secord, Brantford; Dr. George S. Burt, Owen Sound; Dr. J. P. Morton, Hamilton; Dr. F. A. Clarkson, Toronto; Dr. T. S. Farncomb, Trenton; Dr. H. A. Boyce, Kingston; Dr. Fenton Argue, Ottawa; Dr. Edgar, Brandon, North Bay; Dr. E. B. Oliver, Fort William. It was also decided at this meeting that the Fortieth Annual Meeting of the Ontario Medical Association would be held in Toronto on May 26th, 27th and 28th, with the Committee on General Purposes meeting on May 25th.

With regard to University Post Graduate Extension Courses, it was decided to advise the committee in charge of this department to at once get into communication with the various medical faculties and the profession at large, in order that much good may accrue to the profession through this depart-

ment. Members of the profession have already been selected to address district and county society meetings, and it is hoped that in the very near future a bureau will be established in the secretary's office which may be utilized by all local societies desiring the services of outside men to address them.

At an early date each county and local society will receive definite instructions, accompanied by an application form for affiliation with the Ontario Medical Association, and it is particularly hoped that every society will give this important matter the attention which it deserves.

In order that the profession may be kept properly informed as to the activities of the Ontario Medical Association and the work of its Executive during the year, it was decided to have the report of the last business meeting of the Association printed for distribution to the county societies, and also to have synopses of the points of interest decided at executive meetings forwarded to the various medical journals for publication.

F. W. Marlow, *President.*
T. C. Routley, *Secretary.*

CANADIAN SURGEON CHOSEN PRESIDENT OF AMERICAN COLLEGE OF SURGEONS

Dr. George E. Armstrong, of Montreal, was elected president of the American College of Surgeons at the ninth annual Congress, held recently in New York. The election to this office is considered the highest honor in the profession. Dr. Armstrong is Professor of Surgery in McGill University, Montreal. Two British surgeons, a Canadian and a Frenchman, were admitted to honorary membership in the College at the closing session. At the same time five hundred surgeons from every State in the Union were admitted to fellowship, as well as thirty-two Canadians.

The honorary memberships were conferred on Major-Generals Sir Anthony Bowlby and Sir Robert Jones, of the British Army; Dr. Irving H. Cameron, of the University of Toronto, and Professor Theodore Tuffire, of Paris. Of the five hundred

American surgeons admitted to fellowship, there were fifty from the army and fifty from the navy, among the latter being Rear-Admiral Edward R. Stitt.

Dr. W. J. Mayo, President of the College, paid tribute to General Bowlby, who, he said, was responsible for the care of more than 2,000,000 soldiers in France during the war.

STEPS TO COMBAT VENEREAL DISEASE

Dr. J. W. S. McCullough, Provincial Board of Health Officer, recently attended the meeting of the Dominion Health Council held in Ottawa. As the result of the efforts of the Board of Health, the Academy of Medicine and the honorary advisory committee of Military District No. 2, financial aid for the purpose of controlling venereal diseases in Canada has been given by the Dominion Government.

The result of this will be, Dr. McCullough states, that $400,000 will be spent annually for the next three years at least in the control of these diseases—$200,000 voted by the Dominion and an equal amount by the Provincial governments. Of this grant Ontario will receive about $58,000, so that there will be available for venereal disease control in this Province annually over $100,000.

It is proposed to deal with the matter, Dr. McCullough added, by cleaning up the source of the known infection, such as in jails, reformatories and other places of detention. At the same time, by means of the social service of the Hospitals for the Insane, the relatives of parasyphilities in those institutions will be sought out, and the families given proper treatment.

Free clinics will also be established in cities and towns all over the Province, and every effort made to obtain effective control of these infections.

The entire meeting at Ottawa, Dr. McCullough stated, was marked by a thorough feeling of co-operation, and much good was bound to result from the measures adopted.

START COUNTRY-WIDE FIGHT AGAINST THE NARCOTIC DRUGS

Appalled at the spread of drug addiction in Canada during the war years, and finding the Manitoba Narcotics Act powerless to prevent this condition even in Manitoba, where it is declared good legislation is offset by reason of there being no statutory control in provinces east and west, a movement has been formally launched here to establish a Dominion-wide control and regulation of sale and purchase of narcotic drugs. According to Dr. B. J. McConnell, administrator of the Manitoba act, importation of the drugs in Canada has increased since 1912, 35 per cent. for cocaine; six per cent. for morphine, and 600 per cent. for crude opium.

Dr. R. R. McClenahan, formerly of Hamilton, commenced his work in connection with the Provincial Board of Health on October 24th, and will take charge of a campaign against venereal diseases in Ontario. The doctor's first duty will be to get his work organized, after which efforts will be made to treat all prisoners in the jails and reformatories suffering from these diseases. Dr. McClenahan is a graduate of the University of Toronto, after which he took a post-graduate course at the Bellevue Hospital, New York. For a time he was in charge of the laboratory in Military District No. 2, subsequently serving in France and Belgium with the C.A.M.C.

Dr. Still, the founder of osteopathy, became dissatisfied with the use of drugs in the treatment of disease, following the death of three of his children from spinal meningitis. He was led to the practise of osteopathy through the following circumstance: One day while his head was aching severely, he went to sleep in a swing and fell to the ground, his neck being caught against the ropes. When he awakened his headache was gone, and that give him the idea that such cases might be cured by loosening the ligaments. He practised osteopathy for a year without demanding pay. Then he founded his school in a cottage with four rooms. The school had a pre-war enrollment of 700. There are 10,000 osteopaths in the United States.

Personals

Dr. Norman M. Keith wishes to announce that he has opened an office at 232 Poplar Plains Road. He will restrict his practice to internal medicine, giving special attention to renal disease and disturbances of metabolism.

George R. Pirie, M.B., M.R.C.P., London, begs to announce his return to Canada and the resumption of his practice in the disease of infants and children, at 182 Bloor Street West, Toronto.

Dr. W. G. Mackechnie wishes to announce to the profession that he has resumed practice at 96 College Street, Toronto, and will confine his practice to diseases of the nose, throat and ear.

Dr. Leonard Murray has opened an office at 48 Bloor Street East and will confine his practice to diseases of the cardio-vascular system.

Dr. N. O. Thomas, a returned soldier of St. Thomas, has been appointed director of the Provincial Board of Health's new public laboratory at Fort William. He is a fully qualified bacteriologist and the laboratory at Fort William will afford provision for every diagnosis in public health work in the western portion of the Province. Other public health laboratories are already established at Toronto, Kingston and London.

Colonel Dr. Frederick Guest, of St. Thomas, who was overseas during the whole period of the war, has been appointed District Officer of Health in District No. 1, a position rendered vacant by the death overseas of Major D. B. Bentley, of Sarnia. Dr. Guest's headquarters will be in London, and he will have charge of six counties, viz., Essex, Kent, Lambton, Norfolk, Middlesex and Elgin.

Obituary

DEATH OF DR. CHARLES E. TREBLE

Death came very suddenly at noon on October 28th to Dr. Charles E. Treble at Grace Hospital, Toronto. He had not been feeling well and had that morning complained of slight pains in the region of the heart. He had, however, attended to his duties as usual, and his death, which was unexpected, came as a great shock. He fell suddenly to the floor while engaged in the X-ray department of the institution, of which he had charge. The only person present at the time was a nurse, who immediately conveyed the sad intelligence to the chairman of the hospital.

The late Dr. Treble resided at 229 Russell Hill Road. He leaves a widow and four children to mourn his loss, and to them will be extended the sympathy of the entire community.

Dr. Treble, who was about forty years of age, was a graduate of Trinity and Toronto University. He was one of the most prominent X-ray specialists in the city, and, in addition to his post at Grace Hospital, he held the position of X-ray specialist at Wellesley Hospital. He had been connected with Grace Hospital for ten years. He was an M.C.R.S. and L.R.C.P. of London, England, and had spent much time in post-graduate work in England.

Dr. A. J. Macaulay, Medical Officer of Health for Brockville, and a practitioner for the past twenty-four years, died on October 27th, after a month's illness. He was born near Trenton fifty-six years ago, was a graduate of Trinity University, Toronto, and practised at Frankford before coming to Brockville. For nineteen years he had been M.O.H. of Brockville and was a past president of the M.O.H. Association of Ontario.

Dr. Charles S. Elliott, a medical practitioner of the old school, died in Toronto on October 24th, in his eightieth year. Dr. Elliott was born in St. Mary's, educated at Halifax, and in 1856 entered Harvard University, Cambridge, from which he graduated in 1860, with the degree of M.D. He practised at Halifax and North Sydney, Cape Breton, for four years, coming to Toronto in 1864 and practising on Bay Street, opposite Melinda, afterwards settling at Orillia. Dr. Elliott returned to Toronto in 1888, making a specialty of the treatment of nervous and mild mental diseases.

The Journal takes this opportunity of conveying to Dr. and Mrs. W. J. Wilson and their son, Dr. Norman K. Wilson, Toronto sincerest sympathy on the death of the former's youngest son, Mr. Kenneth Wilson, on October 27th, from accidental injuries.

The Physician's Library

Dementia Praecox and Paraphrenia. By Professor Emil Kraepelin, of Munich. Translated by R. Mary Barclay, M.A., M.B. Edited by George M. Robertson, M.D., F.R.C.P. (Edinburgh) Published by license of the Board of Trade under the "Trading with the Enemy Amendment Act, 1916." Price 15 shillings net, postage 6d. Edinburgh: E. & S. Livingstone, 17 Teviot Place. 1919.

Dr. Barclay deserves the thanks of the psychiatric world for her recent translation of the great Kraepelin's clinical investigations of Dementia Praecox. Kraepelin has always appealed to clinicians of experience as the embodiment of charity and common sense, and the fact that his chapters on Dementia Praecox are now available for a large class of young physicians cannot help but prove beneficial. Since the war there has been a tendency on the part of those doing so-called neuro-psychiatry for the first time in their lives to ignore the work of such sound observers as Kraepelin in favor of the unsatisfactory teachings of the Freud and Jung schools. Kraepelin's estimate of such teaching is of the most appealing description to those who have gained their knowledge of psychiatry in the hard school of long experience, and his concluding remarks on the Freudian cult are unanswerable. He says, "Here we meet everywhere the characteristic fundamental features of the Freudian trend of investigation, the representation of arbitrary assumptions and conjectures as assured facts, which are used without hesitation for the building up of always new castles in the air ever towering higher, and the tendency to generalization beyond measure from single observations. I must frankly confess that with the best will I am not able to follow the trains of thought of this "metapsychiatry," which like a complex sucks up the sober method of clinical observation. As I am accustomed to walk on the sure foundation of direct experience, my Philistine con-

science of natural science stumbles at every step on objections, considerations and doubts, over which the lightly soaring power of imagination of Freud's disciples carries them without difficulty. I also hold the view that many speeches and actions of our patients are not so nonsensical as they appear to us, and that sexual emotions certainly play a considerable part in them. But as I only succeed very exceptionally in explaining my own dreams to a certain extent, although the preliminary conditions are certainly as favorable for that as possible, I must not only say explicitly that the statement that a dream "always discloses itself as a sensuous elaboration of a complex," is wholly imaginary, but I am also unable to pluck up courage to give any credence to the disclosures which are yielded by the "analysis" of the processes of consciousness of our patients which are infinitely more difficult to understand. Certainly anyone who can decide to regard the utterances of the patients some times literally, sometimes as the expression of the contrary, sometimes again as "symbols" of any other ideas whatever, who in all these expulsions, displacements, concealments, finds his way with confidence, will not find it too difficult in the end to discover in a fable of Gellert a background of secret incestuous thoughts, jealous, masochistic, sadistic or homosexual emotions."

What he says is undoubtedly the truth and there is not the slightest doubt that much of the incomprehensible twaddle that is often exploited in regard to "complexes" and "symbols" will cease to do duty in due course. Kraepelin's Dementia Praecox should be in the hands of every tyro in psychiatry.

C. K. C.

The Practical Medicine Series. Comprising eight volumes on the year's progress in medicine and surgery, under the general editorial charge of Charles L. Mix, A.M., M.D., Vol. II. *General Surgery*, edited by Albert J. Ochsner, M.D., F.R.M.S., LL.D., F.A.C.S. Series 1919. The Yearbook Publishers, 304 South Dearborn St., Chicago. Price $2.50 per volume, $10 for the series of eight volumes.

This is an especially interesting volume, containing concentrated reports of the fine work in all lines done by the surgeons of the Allied armies, as well as those of industrial surgery. The subjects are considered under the headings of anesthetics, X-ray, new instruments, asepsis, infected wounds, technic, amputations, wound healing, shock, gas, gangrene, tetanus, anthrax and tumors. Then follow chapters on regional surgery. All highly instructive.

Publisher's Department

CLEARING UP SOME MEDICAL "NO MAN'S LAND"

Lying between certain diseases and their present method of treatment there exists a "No Man's Land," as it were, in which the greater part of its invasion has been by the bayonet charge with the surgeon's scalpel. In other words, surgical interference has too often taken the place of medical treatment, and no real scientific therapeutic offensive has been carried out except in certain localities, consequently there is lacking that strong defence which treatment usually brings against disease.

With the increase of scientific knowledge more concentrated attention can be given to those therapeutic measures, which, when combined with clinical results, will enable physicians to eliminate the stigma of these regions.

A brief resumé of a few of these spots and the logical method of clearing them, may be of interest at this time.

Indolent Ulcers.—The patient with a chronic indolent ulcer, whether varicose or otherwise, goes the rounds and becomes a routine patient to almost every physician in his community.

Repeated dressings, washes, salves, etc., are applied and reapplied with the same indefinite results, until the patient, ever with the hope of some new method, seeks elsewhere for a cure.

Broken down tissue, especially that which has become chronic, requires something different than the usual antiseptic and stimulating treatment, for the cells surrounding this tissue are indurated by the inflammatory process and have lost their power of reeuperation. Metabolism in them is at its lowest point, for their vitality has been largely dissipated in defence.

Artificial defence with relief of the induration can be supplied by the doctor, but growth must come from within the cell

itself. The use in this defence of the ordinary antiseptics has a tendency to inhibit cellular functions along with the inhibiting of the bacterial growth.

The treatment must then consist of such antiseptics that do not interfere with cell growth or cell activity. Bacteriologists have found that iodine in one part to four thousand has an inhibiting effect upon bacteria and consequently surgeons are using tinct. of iodine on the skin before an operation, however, the tinct. is found to be strongly irritating in open wounds to produce the best results.

A method of treating these cases, which has been used for a number of years with the best results, is to simply curette away the dead tissue from the ulcer, wash with sterilized water or normal salt solution and then apply iodex not only over the whole ulcer but for about a quarter of an inch beyond the indurated edge and then bind loosely. In a surprisingly short time the redness leaves the edges and true granulation with healing appears.

STIMULATES THE DIGESTION

Careful investigation of the action of Bovinine shows that it acts, primarily, by stimulating the digestive and absorptive processes, and by imparting tonicity to the whole nervous system. The hepatic and the various secretory functions are increased, and a more substantial assimilation of nutriment follows as a natural sequence, and it gives to the system every element required to properly sustain it. In other words, proper balance between waste and repair is brought about.

HYDRAS A VALUABLE REMEDY IN DYSMENORRHEA

The busy practitioner will find Wyeth's Hydras of considerable value in the treatment of dysmenorrhea, colic spasm, and as an anodyne to relieve the pains caused by diseases of the female sexual organs. It is a powerful antispasmodic, though safe; it contains no opiate or any of the habit-forming drugs,

and can be administered freely in variable doses without risk of any danger.

Hydras is the result of extended clinical experiments, a well-balanced formula of Viburnum opulus, Helonias, Hydrastis, Scutellaria and Cornus, dissolved in a palatable solution and aromatized.

"CURITY" HOSPITAL SUPPLIES

By turning to our advertising pages, our readers will notice the advertisement of the Lewis Manufacturing Co., Walpole, Mass. This firm makes a specialty of Hospital Supplies under the trade-mark name "Curity." These Supplies include Gauze, Absorbent Cotton, Bandage Rolls, Adhesive Plaster, Bandages, Wadding and Waterproof Sheeting. These goods are as fine as can be procured anywhere and, once used, will be found to give excellent satisfaction. "Curity" Waterproof Sheeting will give the best of service under the hardest wear.

A THERAPEUTIC AGENT OF VALUE

Riga Purgative Water should be tried by physicians who desire to quickly and effectively relieve systemic tension. It will accomplish the desired object and will be found most effective in abdominal ascites, cardiac dropsy and dyspnea, acute Bright's disease with suppression of urine and cirrhosis of the liver. Try it and you will be pleased with its prompt action.

VICHY WATER IN THE SICK ROOM

Physicians will find Vichy Natural Mineral Water a most valuable aid, particularly in cases of liver disorder, gout, rheumatism, diabetes and gravel. As most physicians know, Vichy is the property of the French Republic, and is always the same, as clear as crystal, free of sediment and a great comfort to any person confined to bed, especially when there is any fever, with parched throat and coated tongue. Doctor, prescribe Vichy Celestins and your patients will thank you.

FARWELL AND RHINES' RELIABLE PURE GRAIN SANITARY SPECIALTIES

"Cressco Flour"—A flour for Dyspeptics, mild cases of Kidney and Liver troubles, Obesity, Debility, Convalescence, etc. Many Diabetics claim to find it of great service, and all they require.

"*Special Dietetic Food.*"—A flour for Dyspeptics and cases of Kidney and Liver troubles requiring rather strict diet, at medium price.

"*Gluten Flour.*"—A flour for Diabetics and marked cases of Acid Dyspepsia, Intestinal Indigestion, Obesity, Rheumatism, and ills arising from excess of uric acid, containing much more protein than required by the U. S. Pure Food Law.

PULVOIDS NATRIUM COMPOUND

We would suggest that physicians write at once to R. L. Gibson, 88 Wellington St. W., Toronto, agent for the Drug Products Co., Inc., of 48 W. 4th Street, New York City, in relation to new indications for Pulvoids Natrium Compound, in which it has been tried and its efficiency fully proven. This literature will be important and interesting.

DIETETIC THERPY

A striking feature of the modern treatment of disease is the increasing tendency to rely less upon drugs and more and more upon supplying the organism with readily digestible and assimilable food, thereby giving tone to the system while stimulating and maintaining at a high level the natural defensive forces. This has given rise to a demand for a food preparation presenting a high concentration of nutritive substances capable of absorption with the minimum functional strain and, at the same time, causing no digestive or intestinal disturbance. Attractive flavor and reasonable price are also desirable features in lengthy treatment. "Ovaltine" eminently fulfils all these desiderata.

"Ovaltine" is a combination of a Diastasic Malt Extract, Milk, Eggs, and Cocoa Flavoring. It is presented in the form of a light granular powder which dissolves in warm milk or water with the utmost readiness, yielding an exceedingly palatable beverage.

AN IDEAL RESORT FOR CONVALESCENT PATIENTS

Physicians have frequent opportunities of referring those convalescing from illness to a resort where they can quickly recover their old-time vigor and enjoy an almost ideal climate, 2,500 feet above sea level. Such a resort is Virginia Hot Springs, just one night out of New York. The management have spent a huge sum of money on this choice spot in "Old Virginny," and are anxious that the Canadian medical profession should continue to refer cases there, as they have done in years gone by. The Homestead Hotel is one of the handsomest houses in America. It is built of solid brick, containing 500 guest rooms, with many parlor suites and 300 private baths. It is spacious, dignified, quiet and restful, with magnificent mountain views on every side. It is no exaggeration to say that Hot Springs means the Homestead Hotel. The Company owns 5,000 acres surrounding the hotel, so that physicians can understand that their patients have every opportunity of enjoying outdoor life and regaining thereby their normal strength.

The dominant factor making Hot Springs world-famous is the cure in which the climate as well as the water assist. The waters are conducted by gravity to the bathhouse and distributed fresh from the ground to the bathing apartments on different floors without loss of heat or its increase by artificial means, and fully charged with all their gases and other health-giving qualities. At none of the celebrated places in Europe, and at no other springs in America, is the temperature prescribed for hot baths that at which the water actually emerges from the earth in the natural springs.

The springs are beneficial, not only for bathing, but for drinking. Besides the hot springs, the effects of which as drinking waters are pronounced, there are magnesia, sulphur, and soda springs within the grounds, and alum water from a spring not far distant. The water from the soda spring comes strong and clear from the ground at a uniform temperature of 74 degrees. Physicians should address for full information Christian S. Andersen, Esq.

R
11
C38
v.46

The Canadian journal of medicine and surgery

Biological
& Medical
Serials

PLEASE DO NOT REMOVE
CARDS OR SLIPS FROM THIS POCKET

UNIVERSITY OF TORONTO LIBRARY

STORAGE